

# The Boston Medical and Surgical Journal

## TABLE OF CONTENTS

June 10, 1920

### THE MASSACHUSETTS MEDICAL SOCIETY

|  |     |
|--|-----|
| THE ANNUAL DISCOURSE—COMPULSORY HEALTH INSURANCE, STATE MEDICINE OR WHAT? By Hugh Cabot, M.D., F.A.C.S., Ann Arbor, Michigan. .... | 595 |
|--|-----|

### ORIGINAL ARTICLES

|   |     |
|---|-----|
| AN EXPLOIT IN CONTROL OF INFLUENZA. THE MEASURES USED MIGHT SERVE AS IDEAL TO ENFORCE DURING ANY PANDEMIC. By J. Madison Taylor, M.D., Philadelphia, Pa. .... | 601 |
| DIFFERENTIAL DIAGNOSIS OF DISEASES OF THE HIP-JOINT IN CHILDREN. By Arthur T. Legg, M.D., Boston. ....  | 602 |
| DR. JACQUES BELINOMME—PRINCE OF PROFITEERS. By J. W. Courtney, M.D., Boston. ....   | 606 |
| PSYCHICAL RESEARCH AND THE PHYSICIAN. By J. Danforth Taylor, M.D., Boston. ....   | 610 |

### CLINICAL DEPARTMENT

|   |     |
|---|-----|
| PERFORATION OF THE CECUM. A CASE REPORT. By Edward H. Riley, M.D., Boston. .... | 612 |
| CONGENITAL CYSTIC KIDNEY: REPORT OF A CASE. By H. Green, M.D., Boston. ....     | 614 |

### BOOK REVIEW

|  |     |
|--|-----|
| The Autonomic Functions of the Personality By Edward J. Kempf, M.D. .... | 616 |
|--|-----|

### EDITORIALS

|  |     |
|--|-----|
| IMPROVEMENT IN HOSPITAL SERVICE. ....                    | 617 |
| THE TREATMENT OF TUBERCULOSIS IN GENERAL HOSPITALS. .... | 618 |
| PROPOSED LAW TO PREVENT ILLEGAL ABORTION. ....           | 618 |
| MEDICAL NOTES. ....                                      | 619 |

### MISCELLANY

|  |     |
|--|-----|
| AMERICAN CLIMATOLOGICAL AND CLINICAL ASSOCIATION. .... | 622 |
| NOTICES, RECENT DEATHS, ETC. ....                      | 622 |

## The Massachusetts Medical Society.

### THE ANNUAL DISCOURSE.\*

NOTE.—At an adjourned meeting of The Massachusetts Medical Society, held Oct. 5, 1860, it was

Resolved, "That The Massachusetts Medical Society hereby declares that it does not consider itself as having endorsed or censured the opinions in former published Annual Discourses, nor will it hold itself responsible for any opinions or sentiments advanced in any future similar discourses."

Resolved, "That the Committee on Publications be directed to print a statement to that effect at the commencement of each Annual Discourse which may hereafter be published."

### COMPULSORY HEALTH INSURANCE, STATE MEDICINE OR WHAT?

By HUGH CABOT, M.D., F.A.C.S., ANN ARBOR, MICH.,  
*Professor of Surgery, University of Michigan.*

It has perhaps been a weakness of the medical profession that it has not sufficiently exerted its great potential influence in directing or influencing the changes in the relation of medical practice and medical custom to the community. We have on the whole been too apt to regard such things as other people's business and held the view that the care and management of the sick constituted our whole relation to the community. But it must now be perfectly clear that with the variety of suggested cures for the real or imaginary evils which are believed to surround the practice of

\* Delivered before the Massachusetts Medical Society, June 9, 1920.

medicine we must think clearly and act together and wisely if we are to prevent various developments which we believe to be unsuited to the requirements. Change is in the air. A demand for a closer relation between the public and its health agencies is wide-spread and proper. Democracy cannot hope to satisfy the claims of its admirers unless it can show success in protecting itself against the diseases of body and mind with which it is threatened.

The present demand for change of some kind has its source in a variety of conditions. Perhaps the most fundamental is a dissatisfaction with private charity as a method of caring for the ills of those who are unable to pay for satisfactory care. The system by which we have provided almost the best skill that the community can afford for the care of the paupers and the derelicts of society has been outgrown. The self-respecting though impecunious citizen demands and has a right to expect that he can obtain care at least equal to the average of medical knowledge without being driven into debt or bankruptcy. Undoubtedly the almost universal adoption of compensation for industrial accidents has started people thinking and they properly inquire why, if they are entitled to protection from accident chargeable against the business in which they are concerned, they are not entitled to insurance against illness

chargeable to the same source. Compulsory health insurance was long ago instituted in Germany and not so long ago the so-called "panel system" of health insurance was put into effect in England. Many people and particularly those dissatisfied with present conditions have heard of these alleged panaceas and believe that they know about them though they are far more apt to hear of their excellencies than of their deficiencies. And finally the widespread demand for protection against illness is part and parcel of the general restlessness of unsettled conditions and the very human though utterly hopeless desire to get something for nothing.

#### COMPULSORY HEALTH INSURANCE.

I do not intend to consume your valuable time with any lengthy dissertation on the much discussed and widely advocated system of health insurance. You are doubtless familiar with the claims made by enthusiastic advocates and most of you have come to an opinion in regard to the propriety of such an arrangement. But in order that no doubt may exist as to my own opinion I will briefly note what seem to me overwhelming objections to this system.

In the first place, as at present advocated in the various bills which are before the many state legislatures of the country, it does not, as far as I am aware, even propose to insure health or to care for the illness of the majority of the population. It is not suggested that any of the systems advocated will have any effect in the prevention of disease or in the diminution of its incidence, and yet the casual minded are rather led to believe that in some mysterious fashion such a result will accrue. It is not proposed, as far as I am aware, to apply this system to all members of the community who are or believe themselves to be financially unable to obtain satisfactory medical attention. It is proposed to apply it only to the workers in industrial concerns where it can be charged against the cost of the business and thus become a tax upon the community which may be borne without being unduly burdensome.

Furthermore, as far as I can judge from the experiments in other countries—and the experiments in England appear very enlightening for us,—the whole tendency of this method

is to promote second-rate methods of practice. The fees which the physicians doing this work can be allowed to charge are of necessity low and this tends to attract chiefly physicians of average or less than average capacity. A more serious objection is that it tends to promote what may be called the method of "pill peddling" in medical practice. It tends to perpetuate the methods of one or two generations ago under which the physician made numerous visits but being unequipped with the machinery for precise diagnosis as a rule contented himself with treating symptoms and trusting to the healing powers of Nature. The last twenty years has seen a great effort to get away from this inefficient method, yet now we are asked to saddle ourselves with a system which is as sure as anything can be to restore to respectability this fast disappearing practice. As part and parcel of this same difficulty health insurance does not assume to provide and probably will in practice discourage the tendency to send patients to a hospital where they can be studied with the best results to themselves and the least expenditure of unnecessary time and exertion by the physician. For these reasons it appears to me certain to promote a method of practice unlikely to promote health or to shorten the loss of time from disease.

Another prime consideration is its effect upon the medical profession who give their lives to it. It has been sometimes argued that this and various other methods would tend to make medicine an unattractive calling. From the point of view of the medical practitioner this is a valid objection. From the point of the community, on the other hand, the medical profession can have no rights which the public is bound to respect to its own disadvantage. If it could be shown, which I think it cannot, that this or some other system would promote health, the medical profession would have no case at the bar of public opinion even though it were sacrificed to the method. But it appears to me quite clear that this method of practice will not only fail as a panacea for the health of the community but will debase the practice of medicine so that all parties will be worse off. Obviously under some system comparable to the "panel system" in England, a premium is placed upon the number of visits or calls that a given practitioner can make. From this it follows that it is clearly to his financial interest to see the least serious cases

and to visit those who live in his immediate vicinity. Obviously to care for the seriously ill is likely to consume time wholly out of proportion to the fee received and sick patients and those who live at a distance are likely to suffer. It might further be suggested that this system tends to promote the sort of snap diagnosis which flourished in the earlier days of the out-patient clinics of the metropolitan hospitals when they were understaffed and overworked and from which we have been trying to escape ever since.

For these and various other reasons it seems to me clear that compulsory health insurance will inevitably work to the disadvantage of the patient, to the disadvantage of the community and to the very grave disadvantage of the medical profession.

But clearly it will not do for us to assume a negative attitude. If we are unwise enough to sit complacently by, it is wholly probable that some system will be put in force which we believe entirely unsound. As evidence of this probability may be taken the situation in England where the organized medical profession opposed the system suggested by Mr. Lloyd George and to a considerable extent refused to assist him in working out some satisfactory method. As a result he went ahead on his own responsibility and there resulted the "panel system" which now bids fair to be most useful as a warning to the unwary.

#### STATE MEDICINE.

The phrase state medicine is commonly used to convey some ill-defined arrangement by which the state shall become the responsible source of medical practice. It is probably often intended to convey the idea that all physicians should become salaried officers of the state. In this form it is probably rarely used as a constructive suggestion but is intended like the Democratic Party in the days following the Civil War to serve as a threat rather than as a plan. There is, I believe, no sound reason for believing that medicine could thrive in such an atmosphere. At best such a service would be comparable to that now existing in the medical establishments of armies and navies the world over and in this form it is notorious that lack of inspiration and degeneration more or less inevitably follow.

But if we are inclined to object to it on the ground that it will injure the personnel of

medicine there will not be lacking those who will oppose it upon other grounds. It is certain to be opposed by those who advocated what they pleased to call "medical freedom" and who yearly appear before our legislatures in opposition to bills proposed in the hope of improving the condition of the public health. It will also be opposed, and not without reason, by those whose business it is to determine how such a method should be financed. If these officers of the state are to be paid sufficiently large salaries to command the services of really first-class men, the bill will be little short of staggering and, coupled with the steady tendency to saddle the state with many expenses which have in the past been thought unnecessary or of private concern, will probably not commend itself to the average legislature.

In this form, therefore, I think we need not consider it in the light of a present possibility. If, on the other hand, we understand this somewhat loose phrase to mean progressive assumption on the part of the state of responsibility of health questions, such a situation now exists. More and more the state has been assuming responsibility for certain phases of medicine, chiefly in the field of preventive medicine, and enormous improvements have been made in comparatively recent times. To progress along this line there can be no valid objection and it is not inconceivable that the time may come when we shall be willing to advise the state to enter more and more into the field of curative as well as of preventive medicine.

If, construing the phrase still more widely, we understand by state medicine the assumption by communities of responsibility for the care of the sick we then approach a phase of the question which is inviting and one in which there is much evidence that activity looking toward definite change is widespread.

We rightly believe that our knowledge of the complicated business of looking after the sick entitles us to be heard. I believe there is no reasonable doubt that we shall be heard if we have a constructive plan and equally little doubt that if we should unwisely confine our efforts to obstruction that we shall receive, if possible, less consideration than we deserve. It is therefore with the hope of stimulating discussion and thought rather than with any overweening confidence that I have a wholly satisfactory plan to propose that I desire to invite your attention to a possible line of de-

velopment which appears to me at least worth considering.

#### ESSENTIALS OF A SATISFACTORY METHOD OF PROVIDING MEDICAL CARE OF GOOD GRADE FOR EVERYONE.

Whatever method we adopt must aim to insure to every member of the community satisfactory medical treatment without requiring him to accept charity or go into debt. It must allow a reasonable freedom of choice or if choice is to be restricted must guarantee a high grade of medical skill. It must reasonably distribute the cost so that it shall not be unnecessarily burdensome and finally it must not interfere with the proper development of the science and art of medicine. We might, perhaps, lay more stress upon this latter point and insist that any system to be satisfactory must show evidence of actually promoting the development of medicine.

In attempting to suggest a method of improving present conditions it is only proper to recognize that various experiments are being tried and with varying though considerable degrees of success.

#### INDUSTRIAL MEDICINE.

This phrase is often loosely used to cover the medical establishments which have been set up by employers for the purpose of caring for their employees. For many years these establishments have been growing and have now been carried to a high degree of efficiency. There can be no manner of doubt that many of the great industrial incorporations now provide for their employees an amount of medical care which closely approaches the ideal. They have wisely provided well trained physicians properly paid and organized their work on a system or variety of systems which would go far to solve the problem if it were satisfactory to what one might call the insured. But it is commonly true that the employees for one reason or another dislike this method. It is alleged that they suspect the evidence of paternalism. It is alleged that they object to this limitation of their freedom of choice and it is alleged that the corporations use the method to their own advantage. Though these allegations may appear shadowy and unsubstantial, there is probably some basis for the widespread

belief that the problem will not be solved in this way. To my mind the greatest objection to this method is that it is a solution carried out privately but charged against the community in the heightened cost of production and yet the community has no voice or control in its management. On the other hand, there is no doubt that these establishments have served and are serving a very useful purpose. For the time being, at least, they give time for the orderly discussion and consideration of the problem and they provide an immense amount of what one might call experimental evidence on the methods of managing industrial accidents, diseases and conditions arising within industry. Whatever method may be finally adopted we shall owe a considerable debt to these pioneers in this method of caring for the sick upon a large scale.

#### GROUP MEDICINE.

The phrase "group medicine" has of late years come into vogue to cover what almost amounts to partnerships between the specialties of medicine. These groups are a serious attempt to solve the problem which we are discussing and have undoubtedly promoted efficiency in the diagnosis and treatment of disease. The chief objection to regarding them as the best method of solving the problem is that they are only incidentally constructed for the benefit of the patient. This benefit consists more largely in increased efficiency than in decreased expense. It is certainly true that in many of these medical groups the financial benefit of the group rather than of the patient has been the commanding consideration.

#### THE COMMUNITY HEALTH CENTER.

By whatever method we may finally decide to care for the health of the community, the fundamental proposition upon which it is based must be that the public health is a public concern. From this it follows that the soundest method will be that which is based upon community consciousness. For this reason I look to some development in the now rather vague field covered by the phrase community center for the solution of the problem.

A great variety of possible developments may be here included. In its simplest form a community may provide itself with a Director of Health whose business it shall be to coördi-



nate existing agencies, encourage coöperation, discourage duplication, and promote efficiency. In this form it is already in operation in various parts of the country. But it may be doubted whether without more means at his disposal such a director will obtain results at all commensurate with the effort expended. A slight advancement from this plan is to provide such a director with a staff of physicians whose business it shall be to keep in touch with the medical activities of the community and go further than he himself could go along the line of influencing medical practice by suggestion and publicity. But again, this arrangement falls short of providing sufficient power and does not enable the director and his staff to exert the authority of public opinion which must at the last analysis always be the ultimate authority.

One of the clearest signs of the times is the tendency of medical practice to group itself about hospitals, and there can be no doubt that in the future of medicine the hospital will play an increasingly important part. For this reason it has appeared to me wisest in any scheme looking to the provision of care for all members of the community to start with the hospital as a basis and create what might be called the hospital center, whose function it should be not only to provide care within its wards but to radiate medicine in the community at large. This possibility appears to me attractive, but to be successful it must have a far broader conception than the municipal hospitals with which we are all familiar. It must take its authority from an educated public opinion which knows, broadly speaking what it wants and is prepared to employ experts to obtain it. Undoubtedly such a method can be worked out, most easily in comparatively small communities where there is a small city and a large area of surrounding country ultimately dependent upon the city for medical service. Under such conditions one might well conceive that some such machinery as the following would work with considerable satisfaction.

*The Hospital.* Such a community might construct and own a hospital with sufficient capacity to take care of something more than the average number sick not only in the city but in the surrounding district which it must serve. It is perhaps not necessary that this should be calculated to provide accommodations for those who ordinarily avail themselves of pri-

vate physicians and private hospitals. But, on the other hand, if such a hospital is to be in fact a health center, it should be constructed so as to provide everything which that community wants for the care of its bodily ills. Obviously in communities of large population, it may be wise to construct several such hospitals, as there is undoubtedly a working unit in hospital construction beyond which efficiency of operation is sacrificed. But for the moment let us assume that a hospital of no gigantic dimensions will fill the bill and let us further assume that it is planned to provide accommodations for all sorts and conditions of men.

*The Board.* In charge of this hospital must be a group, perhaps called a board, who properly represent the wishes of the community, and I believe that this board should serve without pay, so that the only motive for service on the board will be an abiding desire to serve the community. This board must provide itself with a general manager who must, I believe, be a physician, in order that he may be reasonably familiar with the problems with which the board must deal. Such general manager or director must have large powers in executing the policy of the board.

*The Staff.* The board must next provide itself with a staff capable of covering the entire field of medicine and medical research and this staff must be at the service of the community. The problems involved in the selection of such a staff are obviously considerable, particularly if such a hospital is to be started in a community already supplied with a sufficient number though perhaps not a sufficient variety of capable physicians. Clearly this staff must be of more than average skill and equally clearly their skill and qualifications must be beyond reasonable doubt and therefore must be determined by some authority having no interest beyond the determination of the facts. In order, to avoid difficulties the board would probably be well advised to avail itself of the advice of the directors of great medical centers who are constantly engaged in the training of experts in every field of medicine. In order to obtain and retain the services of such a staff, proper salaries must be paid and it may well appear that the provision of such a sum of money will bear heavily upon the community. This difficulty may, I think, in part be solved by allowing this staff to practice in the ordinary sense of the word and to collect fees from such pa-

tients as are able to pay. As the staff, when under this arrangement, would consist of well trained, capable specialists, it would certainly follow that their services would be in considerable demand in the community and that their income from this source would go far to make up the guaranteed salaries which they would be assured of by the board. From this it would result that the community through the board would pay only the balances and might conceivably not have to pay at all.

*The Patients.* Some difficulty will undoubtedly arise in determining what patients are entitled to free care and treatment, what patients should be partly free and what patients can defray their own financial obligations. This difficulty, however, is at least much diminished if we assume that this is in fact a community hospital. It is not difficult if proper machinery be provided to ascertain what are the living conditions of any individual and what is his income relative to his obligations. It we cannot assume that the community really wants to promote its own health and is willing to take any reasonable steps in order to do so, then of course this method will fail, but so will any other method, and on this line of argument the whole proposition becomes insoluble.

#### OPEN VERSUS CLOSED HOSPITALS.

The medical profession will of course be vitally interested in the question of whether this community hospital is to be what is called "open" or "closed." It is, I think, generally admitted that if one has regard only for a high grade of efficient medical practice the closed hospital is likely to give the best results. On the other hand, it is practically a contradiction of terms to refer to a closed hospital as a community hospital. A closed hospital at once denies the freedom of choice which is generally admitted as essential if it is to command the confidence and support of the community. Physicians who are barred, though in good standing, will obviously not send their patients to a closed hospital unless they be compelled to by fear of disaster either to the patient or to themselves. It cannot, I think, be successfully contended that a closed hospital can satisfactorily serve the whole community and therefore some sacrifice of efficiency is necessary in the interest of the community operation. The answer to this dilemma perhaps lies in a combination of the two methods. The

staff provided by the community must obviously look after those patients who are unable to pay and also such other patients as desire their services. Beyond this, the hospital might well be opened to all reputable physicians with the proviso that the board shall have the power to exclude any physician whose work does not match up to a reasonable standard of excellence.

But such a hospital will not have performed its functions if it stops here. It is growing more and more difficult to provide satisfactory medical care for the small villages and the scattered populations of the outlying districts. I am firmly of the opinion that provision for such care is entirely within the function of the community hospital and that unless it serves this purpose it will fail to radiate medicine and consequently fail of its purpose. The work now done by isolated physicians attempting to cover a large area of territory could well be taken over by the hospital, whose business it would be to establish throughout the surrounding country small centers provided with a young physician and one or more nurses. These people would be constantly in touch with the hospital staff, thus obtaining advice, consultation, and comfort. While they should be integral parts of the hospital staff they should be movable rather than fixed and this service should be regarded as a part of the training of the younger men who intend to fit themselves for the practice of medicine in its broadest sense. This line of development seems to me particularly interesting and attractive. It would enable such a community hospital to offer a variety of opportunities, particularly to younger medical men whose capacities are unknown and who might in this way, better than in any other, have an opportunity to survey the broad field of medical practice. The same proposition would hold true as regards the nurses associated with these smaller centers. They would see medicine in its relation to people as is not now possible in the hospital training schools. As a result they would not only be better equipped for whatever branch of nursing practice they ultimately espoused but they would have larger opportunities of surveying the field and thereby learning their own capacity.

I submit this rough sketch of possible medical development for your consideration. It is obviously incomplete, open to objection and its

pathway spread with thorns. I hope that you will find in it the merit of a conscientious attempt at a constructive program based upon the assumption that the community really desires to have its health properly supervised and its illness properly treated. Any scheme which we propose is subject to this consideration, and though it may fairly be doubted whether the community conscientiousness is throughout the country sufficiently developed and crystallized to know its own wants, it is possible that in various places such experiments may be tried and may prove helpful to a final solution.

### Original Articles.

#### AN EXPLOIT IN CONTROL OF INFLUENZA.

THE MEASURES MIGHT SERVE AS IDEAL TO ENFORCE DURING ANY PANDEMIC.

By J. MADISON TAYLOR, M.D., PHILADELPHIA, PA.

THE following succinct but suggestive report was given at my request by Admiral Casper Frederick Goodrich, U. S. N. (retired), who was in command of the naval, army and civilian unit at Princeton University during the pandemic of influenza in 1918.

The facts briefly were these: Admiral Goodrich had under his command all told about 4500 young men. He called his officers together and stated that, as commanding officer he expected them to cooperate fully, to report any suspicious condition, whether symptomatic or inferred. All precautionary measures were clearly outlined well in advance. They proved absolutely complete and efficient and were enforced with military authority. *No deaths* occurred and only an extremely small group of disabilities. My intention was to "write up" the account. It seems, however, that no elaboration could improve this concise presentation of the facts. These were submitted to me by Admiral Goodrich in the following form:

(1) Appreciation of the gravity of the situation while the influenza was still remote; preparation well in advance of the exigency.

(2) Determination to keep it out and not let it get in.

(3) A disinfecting plant was secured in advance.

(4) Every man entering from abroad was sprayed as to mouth, nose, and throat; put through the disinfecting plant,—the man and all his belongings.

(5) An isolation hospital was established at once (the athletic field and the ample training quarters were used.)

(6) Daily rigid inspection of every man by Surgeon and (or) myself.

(7) All droopy men sent to Isolation Hospital.

(8) Walking cases played on base ball field all day.

(9) Cot cases, in the open all day. These two sets kept in sun and air.

(10) A few bed cases kept within doors.

(11) A sanitary board formed of naval surgeon, army surgeon, and local physician.

(12) Closed all movies, churches and schools.

(13) No one was permitted to leave town except in special instances of urgency.

(14) The latter disinfected on return.

(15) Town put in full quarantine.

(16) About 1000 men from Navy, about 2500 men from the Army, and 1000 students. These figures only estimated, but not far from truth.

(17) Complete cooperation by University authorities, Naval and Military officers.

(18) Result—few cases of influenza, fewer still of pneumonia, and *no deaths*.

(19) The results were due to instantaneous and perfect team work.

DR. MARSHALL LEBANON BROWN, of Brooklyn, a retired Fellow of the Massachusetts Medical Society, died at the home of his daughter in Flatbush, Long Island, May 5, 1920, at the age of 83. He was born in New Ipswich, New Hampshire, April 18, 1837, graduated M.S. at Dartmouth in 1861, served as assistant surgeon New Hampshire Volunteers during the war and took his medical degree at Dartmouth Medical School in 1867. He settled in Brighton in 1869 and joined the Massachusetts Medical Society, being retired in 1908. Recently he had lived in Brooklyn. His death was due to heart disease.

## DIFFERENTIAL DIAGNOSIS OF DISEASES OF THE HIP-JOINT IN CHILDREN.

BY ARTHUR T. LEGG, M.D., BOSTON.

[From the Orthopedic Department of The Children's Hospital.]

A great many conditions with origin remote from the hip-joint may refer their primary symptoms, accompanied by physical signs, to an affection of this joint. On account of the great variety of these conditions the diagnosis is often mistaken and, at times, there is great difficulty in differentiating them from affections of the joint itself. This fact has led the writer to classify the final diagnosis of one thousand consecutive cases entered at The Children's Hospital Out-Patient Department with a diagnosis of hip-joint trouble, or where the chief complaint has been referred to this joint by the patient.

The attempt will be made to bring out the essential points in the diagnosis of these conditions by comparison with the symptoms of hip-joint affections, and the difficulties in reaching a correct diagnosis of both.

### CONGENITAL.

*Congenital Dislocation.* Congenital dislocation is generally not recognized until the child commences to walk, when a marked limp on one side is noticed if unilateral, or a waddling gait if bilateral. Physical examination will show an inch or more shortening when one hip is involved, the trochanter above Nélaton's line corresponding to the amount of shortening and abduction markedly limited, with limitation of internal or external rotation depending on whether the head is dislocated anteriorly or posteriorly. On manipulation the head may be felt above the acetabulum. The case will show a positive Trendelenberg sign.

When both hips are dislocated the legs are generally of equal length or may differ slightly, one hip being higher than the other. A marked increase of the lumbar lordosis is noticed in bilateral cases, and although present is much less in unilateral ones. The roentgenogram will confirm the diagnosis.

*Coxa Vara.* While very rare, coxa vara may occur as a congenital deformity. The physical signs are identical with dislocation, except that on manipulation the head cannot be felt above the acetabulum and generally little if any limitation of rotation. The roentgenogram will confirm the clinical diagnosis. While coxa valga may occur as a congenital deformity, the writer has never seen it as such.

*Shortening.* A slight variation of an eighth or even a quarter of an inch in the length of the right or left leg is very common, and often goes unrecognized, but any greater variation will in time become apparent, either by a limp or by pain about the hip, arising from the strain thrown on this joint by the short leg. A markedly short leg will of course be recognized soon after birth, but cases where the variation is from a quarter to three-quarters of an inch may go unnoticed for some years.

A girl of seven years was seen by the writer, having suffered from pain about the hip for two months. There was limitation of motion with marked spasm of this joint and one-half inch shortening of the leg. Roentgenological examination of the hip was negative. Protective treatment and the equalizing of the legs by building up the shoe on the short side permanently relieved these symptoms. These same symptoms of strain may occur in the hip of the longer leg.

It is impossible, of course, to differentiate in some cases between a congenital shortening and retarded development on one side.

### NUTRITIONAL.

*Scorbutus.* Scorbutus, while primarily occurring more often in other joints than the hip, yet quite frequently simulates an infectious process in the hip-joint. The usual history given is that the child cries out when handled, and in very young children it is very difficult to locate the seat of trouble. When the hip-joint is involved there will be tenderness about the joint with limitation of motions from spasm and at times thickening. The temperature may be elevated and the white count increased to a slight degree.



The history of the feeding will usually give a clue to the diagnosis, and if, in conjunction with the pain, there are purpuric spots on the gums (when teeth are present), this will be confirmed.

The roentgenogram will show a sharp penciling of the cortex, osteoporosis, and periosteal thickening where superiosteal hemorrhage has become organized.

It should be remembered, however, that scorbutus may be present, though rarely, in a case where a nonsterile food and even orange juice are being given.

*Rickets, Coxa Vara and Valga.* Acquired coxa vara and valga from rickets may give rise to symptoms of strain or synovitis in the hip-joint and be evidenced by pain and spasm from the altered mechanics.

In coxa vara the physical signs are the same as in congenital coxa vara. Signs of rickets elsewhere, such as enlarged epiphyses, rosary, square head and prominent abdomen will be present. The roentgenogram will show the lessened angle between the neck and shaft of the femur, and if the rickets be acute, will show a small and irregular epiphysis with an irregular flaring or fan-shaped diaphyseal end.

*Osteomalacia.* While osteomalacia is very rare before puberty, this condition is mentioned from the fact that a case came into this series, having been brought to the hospital on account of sudden pain about the hip three days previous, following which the child was unable to walk. There was a fracture of the upper shaft of the femur due to osteomalacia, which was unrecognized up to this time. The roentgenogram of osteomalacia shows a marked osteoporosis and thinning of the cortex.

#### NERVOUS.

*Hysteria.* The majority of hysterical joint affections are seen after puberty, but they are not at all uncommon in children. As seen in the hip, the child "over does" the symptoms of the hip trouble. These come on suddenly, with considerable complaint of pain without apparent cause, and the joint will usually be held in a deformed position, allowing no motion. Negative roentgen examination, absence of temperature and etiological history, with sudden

onset and shifting areas of tenderness point strongly to a hysterical affection. With the child's mind diverted the hip, by persistent gentle pressure, can be brought to its normal position. The diagnosis of a hysterical joint should be made, of course, with the greatest hesitancy.

*Chorea.* The writer recently saw a boy of seven who had had a peculiar limp for two weeks and was brought for advice on account of this and indefinite pain about the hip. All examinations were negative. On careful observation the arms showed slight choreic movements. In a few days his case could be diagnosed as a typical chorea.

*Pseudo-muscular Hypertrophy.* As in the case of chorea just mentioned, a boy was brought to the hospital with a limp and indefinite pain referable to the hip-joint. A careful and complete examination showed markedly well developed lower legs, with extremely weak muscle power, and he rose from the floor by climbing on himself, a typical picture of pseudo-muscular hypertrophy.

#### TRAUMATIC.

*Strain.* Strain of the muscles about the hip, and at times those of the lower back and the sacro-iliac joint, may cause symptoms pointing entirely to the hip-joint. The spasm in strain of the muscles about the hip will cause limp, limitation of motion and pain,—and with an active child who does not think of a slight wrench or bruise, it may be difficult for some days to rule out a more serious affection of the joint itself. In the case of lower back strains, and that of the sacro-iliac joint, tenderness, if present, will be localized in this region, with possibly limitation of motion of the lower back from spasm, but the motion in the hips will be free.

*Synovitis.* Unlike a strain about the hip-joint a traumatic synovitis is generally easily diagnosed, as a trauma severe enough to produce a synovitis can be remembered by the child, and a definite history of trauma, followed soon after by pain and limitation of motion, can be obtained.

*Separation of the Femoral Epiphyses.* On the face of things, it would seem that separation of the epiphyses should be one of the easiest, if not the easiest, condition of the hip on which to make a diagnosis; but the writer has seen

many cases go for weeks without a diagnosis being made. This failure to diagnose arises from the mistaken idea that it is not considered possible for a child after a fall producing separation of the epiphysis, to get up and walk. Yet, nevertheless, it not infrequently happens that a child, after such a fall, will get up, go home and go to bed, or sit about on a chair, suffering perhaps considerable pain, but not severe enough to suggest a fracture. If examined, the leg will be held in eversion, but eversion is present in practically all affections of the hip, traumatic or not; there will be limitation of motion, differing in no respect to that following a simple trauma; *Crepitus* may not be elicited; shortening, if only a quarter to a half inch, may be easily overlooked, especially in a fat individual: shortening of more than this cannot, of course, be missed. This case may limp about for a few weeks, and then be considered to have been a severe trauma of the hip. A roentgenogram would have immediately settled the diagnosis.

Almost identical with this hypothetical case was that of a boy seen by the writer. He was playing ball and in sliding to the base felt a fairly severe pain in the hip. Although not continuing the game he stood about watching its completion. He consulted no physician, and after a few weeks considered himself over the trouble. A roentgenogram taken a year later for indefinite pain in the hip, revealed the exact nature of the injury.

A girl of twelve, who came under the writer's care, had separated the epiphysis of the femur by stubbing her toe while stepping up on

*Flattening of the Upper Femoral Epiphysis.* This condition was first described by the writer in 1909. Up to that time it had been classed amongst various affections, most commonly that of tuberculosis.

It is a non-tubercular condition characterized by limp and limitation of motions, especially in abduction and internal rotation, without pain or constitutional symptoms. The roentgenogram shows a flattening of the epiphysis into a "cap type," where the epiphysis is flat and narrow; or a "mushroom type," in which it is flattened and spread out. There is also a thickening of the neck, giving the appearance of a coxa vara.

It is mistaken for tuberculosis from the fact of its gradual onset without early marked symptoms. The prognosis of this condition is, however, always favorable.

#### EXTRA-ARTICULAR AFFECTIONS.

*Bursae.* The ilio-psoas and gluteal bursae when inflamed, give symptoms referable to the hip-joint on account of their anatomical relation to the muscles about this joint. The former lying on the ilio-psoas muscle will cause flexion of the thigh, and from its spasm, limit the motion of the joint. The latter may cause entire loss of motion of the joint when the gluteal muscles show marked spasm. Infection of these bursae are as a rule acute and will usually show local tenderness.

*Glands.* Retroperitoneal glands when infected, and abscess formation has ensued, will gravitate downward and, if in contact with the psoas muscles, will produce flexion and limitation of motion of the hip, with pain referred to the hip-joint, as did the ilio-psoas bursae. Flexion and external rotation are usually possible. These glands are generally acutely involved with symptoms coming on suddenly and with temperature. The gland thickening or fluctuation can be felt above Poupart's ligament.

*Appendicitis.* An inflamed appendix causing no abdominal symptoms whatever is very rare. Four such cases, however, have come under the writer's observation and have sought advice solely on account of pain about the right hip, limp, permanent flexion, and limitation of motion being present. In these cases abdominal examination has shown a mass in the right iliac fossa, which on operation was proved to be an appendix abscess.

An errand boy with definite pain about the right hip for two weeks, continued work, with some limp, up to the day before seeking advice, when the pain grew much worse, the right thigh becoming flexed. On entrance to the hospital the thigh was flexed 45 degrees. Flexion and external rotation were free, but other motions absent. His temperature was 102 degrees. On abdominal examination a mass could be felt just above Poupart's ligament. Operation showed an abscess from a ruptured appendix.

AN ABDOMINAL EXAMINATION OF EVERY CASE  
SHOULD BE MADE.

*Pott's Disease.* Tuberculosis of the lower dorsal, lumbar and sacro-iliac region will give rise to symptoms in the hip, from irritation of the psoas causing limp from the contracted psoas, and referred pain from irritation of the nerves resting on it. Many such cases of early tuberculosis of the spine have sought advice wholly on account of supposed hip trouble.

A thorough physical examination will decide the diagnosis.

*Infantile Paralysis.* A child of seven complained to his mother, in the morning, of pain in the hip and of a slight headache. As there was severe pain in the hip on walking he was kept in bed and a physician called. He found limitation of motion of the joint, with considerable pain and tenderness and sent the child to the hospital the next day with the diagnosis of "beginning hip trouble." There the examination of the hip was as above described; his foot, however, was in an equinus position with inability to raise it. From this something more than trouble at the hip was suspected, and he was kept under close observation until the next day, when he developed complete paralysis of this leg.

It is not at all uncommon for an infantile paralysis to manifest its first symptoms by sensitiveness about a joint.

*Osteomyelitis.* Acute osteomyelitis of the bones of the pelvis, the neck and upper shaft of the femur, coming on as it does very suddenly, with high temperature and pain, may simulate at its onset an acute infection of the hip-joint itself, as all motion in the hip is usually lost very early from muscular spasm, and the pain produced from infection at any of these locations will be referred to the hip-joint. As soon as thickening can be felt some idea of the location of the process may be obtained, but occasionally there is no thickening about the trochanter, and the exact seat of infection cannot be determined until operation.

Increase of the white count is dependent on the child's resistance.

The roentgenogram in these acute bone infections, when taken early, may be of no benefit in determining the diagnosis.

In the cases of chronic osteomyelitis of the bones about the hip, the history obtained and the early physical examination may be identical

with that of tuberculous hip-joint disease. Thickening in the cases of chronic osteomyelitis, however, can usually be felt earlier than in tuberculosis. In these cases the roentgenogram is all important in deciding the diagnosis and showing the seat of trouble.

*Cellulitis.* An early cellulitis of the upper thigh may, as in osteomyelitis, suggest trouble in the hip-joint by limiting motion at the joint by muscular irritation.

*Bone Abscess.* As with the cases of chronic osteomyelitis, the localized bone abscess of the upper shaft or neck of the femur may simulate tuberculosis of the hip-joint very closely, and the roentgenogram must decide the diagnosis.

*Bone Cyst.* In cases of bone cyst of the upper shaft or neck of the femur, there may be indefinite pain about the hip with limp and spasm, causing limitation of motion of the joint, and the diagnosis can be made from the roentgenogram taken on this account. In the majority of these cases, however, the condition is not recognized until from a slight fall the femur is fractured at the site of involvement, and the diagnosis is made when the roentgenogram is taken.

*Malignant Bone Tumors.* Malignant bone tumors of the upper shaft or neck of the femur may, clinically, as in the cases of chronic osteomyelitis in these locations, strongly simulate tuberculosis of the joint, and from the roentgenogram, differentiation between these and chronic osteomyelitis or bone abscess cannot often be made. The diagnosis is generally suspected, at operation and made by the microscope.

*Syphilis.* Syphilis, as it manifests itself in giving rise to symptoms referred to the hip is generally seen as a periostitis of the upper shaft of the femur. Clinically the symptoms are identical with those of the aforementioned chronic bone infections, and the diagnosis must be suspected by the roentgenogram, and confirmed by the positive Wassermann reaction.

## AFFECTIONS OF THE JOINT ITSELF.

*Haemophilia.* The manifestation of haemophilia in the hip-joint, while not so common as in the knee-joint, may at times simulate tuberculosis, by the pain, tenderness and swelling about the joint; but usually the joint symptoms come on more rapidly. A previous history of

multiple spontaneous ecchymosis, with the family history of bleeders (in males), will determine the diagnosis.

**Acute Infections.** Acute infections of the hip arise primarily or secondarily to the acute infections elsewhere; such as pneumonia, typhoid, the exanthemata, teeth and tonsils and autoinfection. They start as a synovial infection or an acute epiphysitis breaking through into the joint.

By the sudden onset an acute infection can be diagnosed, but as with acute infections outside the joint, the exact location of the seat of infection cannot be made out until thickening can be felt, and this, at times, especially in a fat child, is very difficult. In the very young, also, the evidence afforded by pain may be very deceptive, as they usually cry out and resist any palpation or movement to any part of the leg. Clinically to get joint thickening is of prime importance. The roentgenogram will show a distended capsule with the femoral head pushed out from the acetabulum to a slight degree.

The importance of the early recognition of these acute joint infections cannot be overestimated, as when over distended the capsule will rupture, producing a dislocation, or when the infection starts as an epiphysitis, without very early operative interference, the head will become detached and destroyed.

**Chronic Infections.** The chronic infections of the hip-joint, other than tuberculosis, may, as in the acute infections, be secondary to any of the acute infections, but occasioned by a much attenuated germ. The clinical picture may be identical to that of tuberculosis, and it is at times most difficult to differentiate the tuberculous and non-tuberculous infections.

Given a case of chronic hip-joint infection following soon after an infection elsewhere, or a child with carious teeth, or with a history of repeated attacks of tonsillitis, a non-tuberculous origin of the infection is very probable; but even so, the most careful observation should be made of the case before making a positive diagnosis.

The white count may not be increased.

In tuberculous infection of the hip the majority of cases will give a history of "intermittent limp," which is rare in the non-tuberculous cases, and to the writer's mind this history of onset is of the greatest importance.

The Von Pirquet reaction, while of little im-

portance if positive, when negative is of great importance in ruling out tuberculosis as the etiological factor.

The roentgenological study of the chronic non-tuberculous infections in the early cases is generally negative, but may show some distention of the capsule.

This is also true of the very early tuberculous cases; but in these cases the roentgenogram will later show the "general increased radiability" of the head and neck, which is characteristic of the tuberculosis, and which is not seen in the non-tuberculous infections.

It is, therefore, at times a matter of the greatest difficulty to differentiate between the tuberculous and non-tuberculous infection of this joint, and impossible until the case has been thoroughly studied.

*A most careful history should be obtained.*

*A most complete physical examination should be made.*

*A roentgenogram should be taken in every case of suspected bone or joint disease; and every laboratory method at our disposal should be used before making a positive diagnosis.*

It is not with the idea of complicating the diagnosis of hip-joint diseases that this great variety of conditions is mentioned, but to point out the fact that all the aforementioned affections may refer their initial symptoms to this joint, and that it is at times most difficult to differentiate them.

At the same time, the writer desires to emphasize the extreme importance of early differentiation whenever possible.

---

## DR. JACQUES BELHOMME—PRINCE OF PROFITEERS.

By J. W. COURTNEY, M.D., BOSTON.

DURING the recent world war the view was frequently emitted by certain non-combatant philosophers, comfortably ensconced in their favorite arm-chairs a hundred leagues and more behind the firing lines, that the outstanding product of the greatest shambles known to history would be the purification and ennoblement of all humanity.

Since the signing of the armistice, practically everything in the attitude of man toward man and nation toward nation gives the lie direct to such fatuous and jejune vaticination.



Among honest men existence was never more drab or sorry than at present, for this is the harvest season of the most fearsome and contemptible of all human vultures—the profiteer.

This undesirable citizen by no means dates his existence from the recent war. Manifestly, his prototype was known to Moses, 'for in Leviticus xxv: 14, the latter speaks as follows: "And if thou sell ought unto thy neighbor, or buyest ought of thy neighbor's hand, ye shall not oppress one another."

Profiteers have flourished in every period of great public distress—the result of war (international or internecine), plague, earthquake or crop failure—since the beginning of time. It was to them that Cicero's plaintive reproach, "O, cives, cives, quaerenda pecunia primum est; virtus post nummos," was addressed.

Representatives of every stratum of society are found in their loathsome ranks. Taine, in his *Origines de la France Contemporaine*, tells us that it was cupidity as well as hunger which drove the revolutionary French peasantry to forcible seizure of storehouses and granaries, and instances cases where the precious contents of these repositories were generously disposed of by the same *sans-culottes* to their affamished brethren at a modest profit of one hundred per cent. In this connection it is not without interest to note that the attention of the infamous Constituent Assembly of revolutionary France was but indifferently occupied with the case of one Gerdret, accused of having furnished to the army boots with cardboard soles, on the afternoon of the fateful twentieth of November, 1792, when Roland burst in upon it with the newly discovered private papers of Louis XVI, a find which served to send that monarch to the guillotine.

Of all the profiteering band which the present writer has come upon in his miscellaneous reading, no other figure is quite as interesting as that of Doctor Jacques Belhomme. It appears that in 1787 this philanthropic alienist, with a keen eye to favorable environing conditions, established a comfortable "Retreat" on the vine-covered highland of the rue de Charonne in the suburbs of Paris. The success of the establishment was quickly assured. Within less than two years it counted forty-six inmates, of which number but nine were "voluntaries." Among the latter was a cer-

tain *abbé* who suffered from the fixed idea that he was a famous actor and wore himself out trying to declaim tragedies in their entirety, without any stop for breath.

When the Revolution broke out, Dr. Belhomme—a liberal, like many other physicians—was named captain in the company, Popincourt, and had the happy inspiration to offer to his section the "Retreat," the purpose being to shelter there, for a consideration, and under pretext of arthritides to be nursed and quartan fevers to be cured, rich suspects to whom the prospect of a sojourn in a vulgar prison was eminently distasteful. The doctor was on excellent terms with several powerful men of the new régime, his proposition was accepted, and there soon began to arrive at the "Retreat," from all the jails of Paris, prisoners with swollen incomes who, although hated aristocrats, managed by force of *pourboires* (!) to procure this favor.

It was indeed a favor, as one may judge by the fact that, while the agents of the public accuser recruited daily their guillotine fodder from the jails of Sainte-Pélagie, the Madelonnettes or l'Abbaye, it was a matter of comment that, through grant of a very special privilege, not a single soul who found refuge with Dr. Belhomme was hailed before the tribunal. Furthermore, it was well known that although the revolutionary air of other parts of Paris was peculiarly mephitic for aristocrats, that which circulated about the grounds of the spacious, vine-covered "Retreat" in the rue de Charonne was, for them, salubrious beyond words. There the cerberus on guard was as tame as a house-cat, the bars at the windows pleasantly inconspicuous and not overladen with unsightly padlocks. One was permitted to saunter at will about the grounds, and there were no restrictions with respect to visitors. In brief, the "Retreat" soon became for the poor hounded suspects among the aristocracy a coveted oasis which Death, ever stalking elsewhere, never approached—a sort of enchanted isle of an Arabian Nights tale. Incidentally, it was whispered about that Belhomme had obtained for his house "a tacit protection" very lucrative for everybody concerned. There were those who had the temerity to assert that there was a personal "arrangement" between the doctor and no less a person than the public accuser, the redoubtable Fouquier-Tinville, by which the latter was

pledged not to annoy the doctor's house guests.

It is not remarkable, under the circumstances, that Belhomme was soon almost at his wits' ends to find lodgment for an ever-increasing clientèle. The fact that he enjoyed the able concurrence of a self-appointed band of *runners*, among whom one Vilain (!), who, for a paltry five or six thousand pounds, made admission practically certain, surely did not serve to relieve his embarrassment. But he was eminently obliging and resourceful and, if one were not averse to somewhat exiguous quarters, there was always available a corner in the garret at four hundred pounds a month or a cosy little sleeping apartment for three at five hundred. In the end, however, it became necessary for the doctor to rent a neighboring hotel—The Chabonais—which vast gardens separated from the "Retreat."

Life at Dr. Belhomme's was very gay. In the evening a long file of carriages was drawn up before his door. Within there was gaming, laughter and music; and not the least note of liveliness was that contributed by the prettiest actress of the Théâtre-Français, Mlle. Lange, and by her chum, Mlle. Mézeraï, neither of whom could bring herself to take the Red Terror seriously enough to repulse the attentions of opulent adorners.

It is true that the gay company of "voluntaries" were at times exposed to annoying contact with the "certified" patients (maniac-depressives and demented, disturbed by the hurly-burly of the household) whom Dr. Belhomme, despite his understanding with the reigning powers, was unable to evacuate. But, after all, where life is at stake, one quickly grows tolerant of petty vexations, and it must have been most comforting to the "voluntaries" to feel that their own heads were not only not cracked but still firmly attached to their shoulders, while those of friends and relatives were daily dropping into the gathering-baskets of the guillotine, to be paraded later on pikes by frenzied viragos through the streets of Paris.

As a business man, Dr. Belhomme was noteworthy straightforward and clean-cut. He wasted no words in making it crystal-clear to his "patients" that his sole concern was a purely medical one—the preservation of life. His fees were on an ascending scale, payable monthly; and at the end of each month it was compulsory for everybody in the "Retreat" to

liquidate. Incidentally, it was prudent to bargain for the next month's respite from the scaffold, for the unfortunate who could not hope to pay was immediately transferred to the Conciergerie, St. Pélagie, or some other prison not under the protection of the public accuser.

Let it not be inferred from the doctor's business methods that his manner toward his patients was voluntarily harsh or hateful in any way. On the contrary, he tolerated their antic frolicsomeness with paternal good nature. Indeed, he did not conceal from them his weakness in allowing himself to harbor a strong attachment for them, and it was always with the chill of death in his heart that he announced to those whose resources were at an end that he found himself under the dire necessity of sending them to the guillotine. It is related that he compelled, with such fatherly tenderness, the charming duchess Béatrice-Yvonne de Choiseul, who could not pay his "fees" and was unrightfully usurping the place of a solvent client, to listen to reason, that they parted the best of friends, the duchess going to the Conciergerie and thence, in a few days, to the scaffold.

The one thing Belhomme could not tolerate in his clients was ingratitude. "Really," said the duchess du Châtelet to him one day, in the somewhat affected manner of the *grande dame* of the *ancienne cour*, "really, Monsieur de Belhomme, you are unreasonable and, to my keen regret, I cannot satisfy you."

"Tut, my plump one," replied the jovial doctor, "be a good girl, I'll make you a rebate of twenty-five per cent." But, even at this figure, the duchess was unable to continue to pay her "pension." She was compelled to quit the establishment, and a few days later died on the gallows. This catastrophe scattered consternation in the "Retreat" Belhomme. The doctor himself was visibly affected by it and remarked, by way of pointing an example, that "her ladyship perished the victim of ill-advised economy."

In order that he might not overlook any available funds in his protégées' possession, he employed the services of a *citizeness*, variously called Chabade and Chabanne, whose principal duty was to levy taxes. That this factotem had a busy time of it may be judged from the fact that the sums paid by the individual guests monthly to the doctor in person—sums

which varied in amount from four hundred to a thousand and more pounds—secured for them absolutely nothing beyond four sheltering walls. Everything else—hair dressing, heating, laundry-work, furniture, coffee, cream, sugar, . . . etc., was extra,—the last-named commodity holding all records for altitude on the part of prices.

When the citizenship was not occupied with these ordinary levies, she busied herself with certain gleanings—surprises the resourceful doctor called them. The ingenious notion was his own. These surprises took the form of *Collections for the Section, Offerings to the Patriots, Subscriptions to the Saltpetre Fund*, . . . etc. Their object was to make sure that no last pieces of gold should lose weight by attrition in the purses of the guests.

The common table of the "Retreat" was notoriously bad. There were no fixed hours for service. Luncheon might be at two in the afternoon or six in the evening, so it came to be the custom to form a bread-line at the dining-room door and make a frantic rush for the tables directly the door was thrown open. Each table of thirty covers had food for eight persons only. Naturally, it was a case of "the devil take the hindmost." One could, to be sure, have meals sent in from the outside, but the argus-eyed citizenship was ever on the alert, and upon every importation of this sort there was levied a customs duty, either in money or in kind—fruit, a cutlet, or a bottle of wine—and it was of these preliminary levies in kind that their hodge-podge of a *table d'hôte* was composed.

Small wonder that Belhomme's speculation—the "Retreat"—was fruitful and the dividends "important." Small wonder, also, that he hoped that the Revolution would go on forever. But such was not to be his happy fortune. The Popincourt section conceived the troublesome idea of sending to his peaceful institution two penniless prisoners in the philanthropic hope that the poor devils might live on the crumbs fallen from the tables of the rich. There were no crumbs. Belhomme lamented the fact and sought to extricate himself from the dilemma by taking up a collection from his protégées in favor of the intruders. This expedient yielded next to nothing in the way of practical results. The intruders became noisily exigent. The doctor exhorted them

to resignation, reminding them that even the most exalted of the nobility under his care were content with the ordinary rations. The intruders were inexorable and embodied all the rancor of their outraged sensibilities in a denunciation of the citizen Belhomme, which was forthwith despatched to their section, and which charged him with "exercising vexations, exactions and extortions, demanding from the rich exorbitant sums, paid in advance, and treating inhumanely the poor *sans-culottes* less favored by fortune."

In consequence of this denunciation, in which the inhumane treatment of the poor *sans-culottes* is so touchingly stressed, Belhomme was placed under arrest and charged with extortion and incivism. By a sort of poetic justice he was, in course of time, interned temporarily in a rival *maison de santé*, where an indelicate confrère administered to him heroic doses of his own medicine. Thence, by a verdict of the criminal tribunal, he passed to the galleys to "do a stretch" of six years.

After the doctor's enforced departure the "Retreat" was "courageously administered," so the archives tell us, by Mme. Belhomme, for it appears, there was a Mme. Belhomme. However, with the advent of the 9th Thermidor, her duties could not have been onerous, since, after that auspicious date, the only remaining inmates were a few demented interned before the Revolution.

Belhomme returned to his institution in the Spring of 1798, after serving four years of his sentence. The original Mme. Belhomme was not there to welcome him. Whether she had meantime died, or whether she had passed out of his life through the medium of the divorce court, is a matter which will probably never be determined. We do know, however, that the worthy man, then sixty-one years of age, lost no time in entering into marriage contract number two—the new spouse being but twenty—and that in happy union with this new directress he carried on the "Retreat" for a further period of twenty-six years, at the end of which time he died. By the most singular combination of circumstances imaginable his relief remained in absolute ignorance of both his own shady character and that of his institution during thirty years of her widowhood. And when the truth was finally laid bare to her through the published *Souvenirs*

of one of the hated aristocrats who had found asylum with the doctor during the Red Reign, she indignantly characterized the revelations as a tissue of falsehoods. Thus was virtue ever rewarded.

### PSYCHICAL RESEARCH AND THE PHYSICIAN.

BY J. DANFORTH TAYLOR, M.D., EAST BOSTON, MASS.

SIR OLIVER LODGE, an eminent English physicist, has recently delivered lectures in this country upon the subject of "Discarnate Intelligences, Telepathy (thought transference without the use of the senses), and the Reality of Psychic Force."

Many physicians of a skeptical nature will laugh at the idea and pass it by with little or no thought as to the consequences. It is most essential, however, that medical men should realize the import of such influences and use their utmost power to combat such theories.

In England, where the whole country has been stirred up by the teachings of Sir Oliver Lodge, Dr. Conan Doyle, and others, a great wave of mediums and fakirs has overflowed the island, reaping a rich harvest from the unwary and credulous.

After one gets a message from a departed loved one and has had mental troubles relieved, the next step is to seek the same measures for the relief of bodily ailments. Here lies a danger that may invade the province of medicine.

Several years ago, the author of this article pointed out, in a paper entitled "Emotional Religion and Mental Impairment," the danger of brain lesion under extreme emotional stress.

The same danger to the people exists today as a result of indiscriminate experiment and investigation in "spiritualistic" fields.

The craze for "psychism" is liable to spread through all ranks of society, the result being an accentuation of the increase in morbidity, in neurasthenia, and in downright insanity.

The freak religions tend to become medicinal. They are offered for their healing properties, and persons accepting them and not dying of the first ailment suffered, give them the credit for working a miracle. A Biblical text is often used as the basis of authority for the founding of a healing cult, such as the eleventh and

twelfth verses of the nineteenth of Acts: "And God wrought special miracles by the hands of Paul; so that from his body were brought unto the sick handkerchiefs or aprons, and the diseases departed from them, and the evil spirits went out of them."

Sir Oliver Lodge has been justly criticized as being incapable of good scientific work along those lines because of his lack of training in biology and psychology, and partly through temperamental reasons, whereby his bias unconsciously lowers his critical standard, so that he is continually giving the benefit of the doubt to mediumistic phenomena and omitting to take obvious precautions against fallacies.

Scientific belief should depend solely on the weight of evidence and not on the controversial usefulness of some hypothesis. Before a supernatural explanation is invoked, it is a good rule of philosophy to exhaust the possibilities of the normal, and so coincidences, as an explanation, can be excluded only when the chances against any particular combination are almost infinite.

Scientific proof also demands the possibility of the repetition of the observations under conditions which are understood or can be controlled in order that verification of the facts may take place.

Sir Oliver Lodge's book, "Raymond," is an example where his bias has unconsciously lowered his critical standard; the work being full of such defects. His simple trustfulness is also shown in his report on the work of the medium, Eusapia Palladino.

The record of "Mrs. Brittain," Sir Oliver's latest medium, is worth studying. She made claims of "clairvoyance" in 1910, in England, advertising her marvelous powers of thought transference. One of the English police, disguised as a farmer, paid her a visit. She not only made a number of incorrect guesses about his circumstances, but her so-called "clairvoyant" powers failed absolutely to recognize his connection with the police. She was arrested and convicted for fortune telling.

The things which scientists call untrustworthy observations, Sir Oliver calls facts. The same applies to Conan Doyle, who is most dogmatic in his statements.

Is it not a waste of time to make observations so long as the conditions are such that fallacies cannot be excluded? To accept conditions of a so-called "medium," to submit to inferior



conditions, is to unconsciously lower one's own critical standard.

Under the emotional and unscientific conditions of the "sittings" with the mediums the judgment becomes warped and one becomes impressed by phenomena which leaves the critical reader quite cold.

William James pointed out that "continuous sittings will almost always produce a cumulative effect on the mind of the sitter whose affairs they implicate, and dispose him to the spiritistic view. It grows first plausible, then possible, then natural, and finally probable in a high degree."

J. F. Rinn, a former member of the Society for Psychical Research, who took part in the exposure of Palladino, and who has made a hobby for years of exposing so-called "supernatural" phenomena, recently offered \$5,000 if anyone could produce a medium who could offer under scientific conditions, the slightest evidence of communication with the spirit world or supernatural feats of any kind.

There is no limit to the range of scientific inquiry; but knowledge can be advanced only by taking every possible precaution against fallacies, and when this is done, phenomena requiring supernormal explanations are conspicuous by their absence.

The realm of spiritualism affords an excellent field of investigation for the psychologist and psychiatrist, and also for the sleight-of-hand performer who would learn new tricks.

As psychology is the description and explanation of states of consciousness as such, all the emotions, sensations, desires, volitions, reasonings, decisions and cognitions come within the scope of its investigation.

The demonstrable manifestations of the hidden workings of the subconscious mind are well known to science. They give a natural explanation for "spirit communications."

Just as the gods of any religion are inductions from experience, and religious "experiences" are states of consciousness and are therefore proper objects of scientific investigation, so the investigation of "spirits," as such, comes within its scope.

The physician is supposed to be a scientific man, trained to use rational methods of research to prevent and alleviate disease, whether mental or physical. It is his first duty to protect his business, his own peculiar method of

specialized industry, by which his intellectual labor obtains its pecuniary reward.

His method of preserving public health is based on the knowledge derived from a study of the various natural phenomena. While medicine is not an exact science, its votaries strive to use scientific methods in all their undertakings.

Primitive man assigned life to all objects, animate or inanimate. All life is of the same kind and, therefore, the primitive philosophy assumes the possibility of life passing on to another form, a point of view that is illustrated in the folk tales and myths, so widespread, of men being changed into animals or trees.

This theory survives in advanced forms of religions in the doctrine of the transmigration of souls, as in Buddhism, where the same vital essence, it is assumed, may appear successively in a tree, in an animal or in man. In another direction it leads to the belief of the incarnation of a deity in human form, a belief found in many religions. (A Hebrew peasant, called Jesus the Christ, was an example, a believer in spirits and demons.)

Men in the primitive state pictured all disease as being due to some active, living force that has found its way into the body. The conclusion is a natural one and, in a way, seems to have anticipated the modern germ theory.

A cure, therefore, involves the expulsion of the hostile power and the medical treatment was usually exorcism; for the imagination of primitive man conceived the germ as obliging enough to take on tangible shape.

Some modern religions have developed a dualistic theory, whereby a spirit or soul inhabits a material body and leaves that body at the time of the death of the physical body. It bears a definite relation to the theory held or attributed to primitive man, and is most readily adopted by the credulous, emotional and simple mentality.

Just as the priests and parsons are the mediators between a god and mankind, and develop a powerful organization for personal profit from the "believers," so the medium acts as the middleman between the "spirit" and the message-seeker.

Both systems appeal to the primitive and childlike mind. The search for discarnate intelligences has already become more than a

cult and its adherents are many. Drawing the attention of man from the realities of this world to the frictions of an imaginary one, has resulted in religious doctrines entailing much misery to mankind.

So far as civilization has any definite aim, that aim must be the increase of human happiness. The means to the attainment of this object are material comfort and prosperity. The removal of ignorance and the growth of knowledge are, therefore, necessary to the development of happiness.

A system of dogmatic religion of any kind, such as "chasing the spirits," depraves morality, benumbs the mind of man and debases human nature.

Where in the realm of science has a discarnate intelligence been found? Is there any reason why we should not apply the same methods of investigation in studying the unknown that we use in studying the known?

Has science ever demonstrated any dualistic nature of man, any separate entity apart from the matter of which the body consists? Mind is looked upon as the functioning power of the brain, but how can a mind or intelligence exist apart from the brain, a material product?

In 1916, the Open Court Publishing Company, of Chicago, brought out a book entitled, "Behind the Scenes with the Mediums," by D. P. Abbott. Any physician who wishes to become a "medium," a message-reading, slate-writing, and table-tipping expert, is referred to this work.

It is the duty of the physician to combat all cults that are not based on scientific facts. And furthermore, it is time that all medical men place themselves on record as *defenders of science* and as opponents of those things which impede progress, impair the mind of man, and subjugate his mentality to a parasitic class.

Go to the Psychopathic Hospital and tell the physicians there that you have had messages from the dead, that you are in communication with spirits, and that you have "psychic" powers and see what will happen. You will at once be classified as one who is suffering from delusions, hallucinations or illusions, according to your story, and the chances are that you will be detained for further observation, as to your sanity. "Who ever heard of a psychiatrist who believed in spirits?"

Modern medical science has fought its way

from the primitive belief in exorcism and magic, to the rational administration of various remedies for the cure and prevention of disease.

Every step in its advancement has been met with opposition by organizations claiming divine authority, and the office of mediator between the known and the unknown world. Without the use of incantations, prayers, holy bones, holy relics or blessed shirts, medical science has become one of the true and actual saviors of the human race.

The realm of spiritualistic phenomena is largely "bunk or fake" and sleight-of-hand. It is the sum total of all the superstitions of the past, the destruction of which has always been the chief purpose of science. The science of psychology and psychiatry gives a natural and sane explanation of spiritual phenomena.

Let the medical profession unite for further victories in the interest of humanity.

### Clinical Department.

#### PERFORATION OF THE CECUM. A CASE REPORT.

BY EDWARD H. RISLEY, M.D., F.A.C.S., BOSTON.

It is desired to report the following case because of interesting points in postoperative findings and because of the several postoperative complications with eventual complete recovery.

M. M. C. was seen at 4 A.M., December 23, 1918, after having been in bed one week with an attack of epigastric pain, nausea, and vomiting, and obstinate constipation accompanied by temperature varying from 97.2° to 100.4°. Because of a previous history of a chronic "stomach trouble," with acute exacerbations, the present attack was diagnosed, in the absence of lower abdominal signs, as probable gall stone colic, by the attending physician. Not until 1 A.M. of the day I was called in had there been any signs or symptoms of a possible lower abdominal lesion. At this time, however, the temperature had gone to 102°, there was violent pain in the whole lower abdomen, and rigidity in the right lower quadrant.

Examination showed an abdomen typical of acute, ruptured appendicitis with beginning general peritonitis. The upper abdomen was soft and only very slightly tender to palpation. There was no evidence of obstruction. Immediate operation was advised and accepted. The

patient was brought to Boston and was operated on at 6 A.M., ether being administered by Dr. Freeman Allen.

On opening the abdomen, a large amount of foul, colon-smelling, yellowish-green fluid and pus escaped, which also carried with it a strong odor of turpentine, and, when an entirely sloughed-off, gangrenous appendix with a perforation of the cecum  $1\frac{3}{4}$  cm. in diameter was found, it was taken as undoubted evidence that the fluid free in the peritoneal cavity was none other than the turpentine enema given a few hours before the sudden onset of right lower quadrant pain. This apparently marked the time of perforation of the very necrotic appendix and cecum.

The cecal opening was closed with a zero gut stitch, three cigarette wicks placed; one to the stump, one to the right flank, and one to the pelvis and the wound closed in the usual manner. The patient was returned to bed in very good condition but because of the general peritoneal involvement a bad prognosis was given.

He had a stormy convalescence, septic petechiae developing over the chest on the fifth day. On the eighth, seventeenth, and twenty-first days there occurred profuse secondary hemorrhages from deep in the wound. The patient was fortunately reached by me very soon after the onset of each hemorrhage, gas was given, the wound inspected—no bleeder found—and the wound packed. After the second hemorrhage the patient's condition was so precarious that Dr. G. W. W. Brewster was called in consultation but advised against any operative interference. Patient made uninterrupted and satisfactory recovery without transfusion, after the third hemorrhage, and was discharged February 14, 1919, in excellent condition.

He remained well until about August 1, 1919, when he began to have sudden severe attacks of acute epigastric pain, without nausea, vomiting or distention. Attacks were often relieved by enemata, but might come on shortly after an unaided stool in the morning. Attacks thought to be due to adhesions involving colon,—probably the transverse portion. Attacks continued at rather regular intervals in spite of careful diet, mild laxatives and occasional enemata.

September 4, 1919, entered Deaconess Hospital to be under observation while gastrointestinal x-rays were being taken and so that patient could be watched during an attack.

Patient previously seen by Dr. C. H. Lawrence, who considered condition probably due to adhesions and spasm. Dr. Morrison's report showed absolutely no evidence of adhesions or obstruction and no pathology in relation to the stomach. In conversation with me regarding this case, Dr. Morrison stated that had he not known that the patient had had a previous general peritonitis, he should never

have known from the x-ray findings that the peritoneum had ever contained any adhesions.

Patient had no attack during a week's hospital observation but on the night following his arrival home he experienced the worst attack he had ever had. No relief was obtained from atropin or several doses of morphia. The temperature was reported by the attending physician as  $101^{\circ}$  and the patient was advised to return to Boston for further study. He was seen by Dr. C. H. Lawrence and myself at 7 P.M., on the day of his attack. Temperature was  $100^{\circ}$ . There was mild pain, but the physical examination was absolutely negative. There was no distention. Even deep palpation could elicit no tenderness, rigidity or spasm anywhere in the abdomen. Operative interference did not seem indicated and it was thought best to see the patient in an attack if possible. However, on September 11, 1919, the temperature went to  $102\frac{1}{2}^{\circ}$ , the white count previously 18,000 to 28,000 and the patient looked sick for the first time, and a very slight amount of tenderness was found in the epigastrium, more to the left than to the right of the median line. This corresponded to the site of most of the previous pain complained of. Operation was advised and accepted. Ether was given by Dr. William L. Dodge. The abdomen was opened through a median epigastric incision. Much to my surprise, the whole peritoneum, as far as could be inspected and palpated, showed absolutely no signs of past or present inflammation. It looked like a virgin peritoneum everywhere; even at the site of the old infection there were only a few fine adhesions of the cecum to the abdominal wall. The total absence of any sign of the old diffuse and virulent peritonitis was a very surprising revelation. No pathology was found in the stomach, colon, pancreas, or intestine. Finally, a small tongue of omentum was seen pointing downward toward the right kidney region, and, tucked far underneath the costal margin and very deep in the flank, a gall bladder distended to the size of the fist was found. A cholecystectomy was easily done and on section the bladder was found distended with thick, foul pus, whose drainage was prevented by the impaction in the cystic duct of one small mulberry stone. Three cigarette drains were placed and the abdomen closed.

The patient made an uneventful and satisfactory recovery with flat, normal temperature. All wicks were out and the patient was preparing to go home in a few days, when on the eighteenth day the temperature rose to  $101^{\circ}$ , patient had a chill, and a diffuse, deep red rash appeared on chest and abdomen. The abdomen was soft and there was no tenderness. There was a little serum from the wound. The next day temperature went to  $103\frac{1}{2}^{\circ}$  and the patient was lobster-red all over. In Dr. Lawrence's absence, was seen by Dr. William

B. Robbins, who could find no evidence of scarlet fever and a diagnosis of toxic erythema was made. That night the temperature went to 105° and the white count to 32,000. The patient's condition seemed desperate. Suddenly at 1 A.M., he began to perspire and did so so profusely that his bed had to be changed three times during the night. At 9 A.M., the temperature was normal and remained so until discharge twelve days later. Patient has remained perfectly well ever since, has gained weight, and shows no ill effects from his almost overwhelming but fortunately short-lived toxemia.

The points of especial interest in this case are the following:

a. Finding of a recently given turpentine enema free in the abdominal cavity, its entrance being through perforation in the cecum where a completely gangrenous appendix had been sloughed off. The question may, of course, be raised as to whether or not the turpentine enema did not actually produce the perforation or at least hasten it by several hours.

b. Recovery from general peritonitis and three secondary hemorrhages occurring as late as the eighth, seventeenth, and twenty-first days after operation.

c. Later finding of "virgin" peritoneum with no adhesions even after so severe a peritonitis.

d. Unusually late, overwhelming, but short toxic erythema with sudden onset and equally sudden recovery.

### CONGENITAL CYSTIC KIDNEY: REPORT OF CASE.

By H. GREEN, M.D., BOSTON,

*Junior, Assistant Visiting Physician, Children's Hospital.*

[From the Medical Service of the Children's Hospital.]

In looking over the records of the Children's Hospital I have found only three cases of congenital cystic kidney. It is a rare condition in infancy. The condition is usually found bilateral. The contents of the cyst are usually clear but may be tinged with blood pigment. Virchow believed that the condition was one of retention cysts due to fetal nephritis. Another theory is that the condition represents a true developmental anomaly, with the formation of cysts instead of normal renal tissue (Ranvier).

A third theory is that the condition is due to the failure of the developing tubules to unite with the corresponding glomeruli or an excess of either glomeruli or tubules and cyst formation in the supernumerary structures.<sup>1</sup>

If the kidneys are of normal size, as they may be, there will be no symptoms. If the kidneys are large the condition will be considered among the abdominal tumors of infancy. The prognosis depends on the amount of parenchyma involved. In the tumor type death usually occurs in early infancy.<sup>2</sup>

Report of Case: E. C., two years old. Came to the Out-Patient Department of the Children's Hospital.

*Family History.* Only child of healthy parents. No exposure to T. B. or contagious disease. One miscarriage before child was born.

*Past History.* Full term, normal delivery. Birth weight, 6½ pounds. Breast fed six months. Since that time was fed on mixtures of proprietary foods and condensed milks.

*Present Illness.* Past eight months child has had spells of "getting blue," coming usually in the morning. Has had them every day for the past week. Usually last fifteen minutes. Mother has also noticed a yellowish-white discharge on the diaper. Urine has been dirty white. Eyes have been puffed, but mother has not noticed that the body was swollen. Appetite good. Cough for past two weeks.

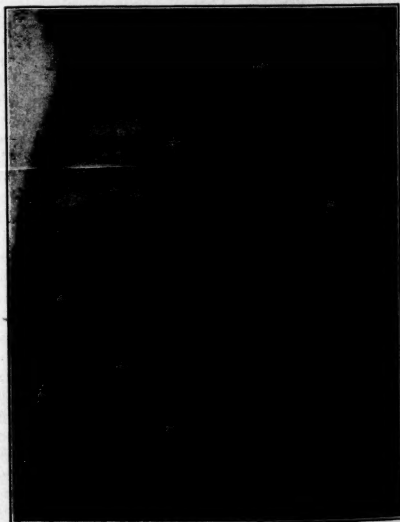


FIG. 1.



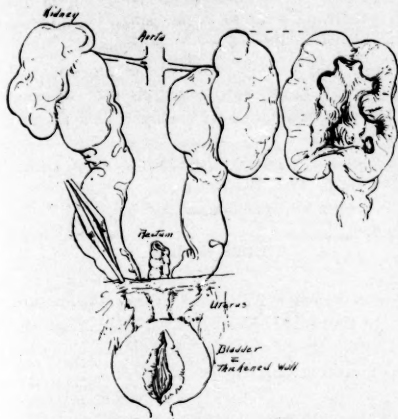


FIG. 2.

**Physical Examination.** Very flabby. Fontanelle closed. Throat reddened, no glandular enlargement. Chest respiration noisy as though there was some obstruction. Lungs clear. No râles. Heart sounds regular, no murmurs. Abdomen held tense; legs in position of knock knee.

On account of peculiar respiration child was sent to the throat room. No foreign body in throat or lungs. X-ray taken. Interpretation: Tracheal stenosis from thymic pressure. One month later child entered hospital in a moribund condition. Family and past history as above. Was admitted to hospital wards. History: At birth was a very pink red baby, had no blue attacks. Between nine months and one year of age parents noticed that child became definitely blue at times and seemed lifeless. These attacks have continued at varying intervals. For the most part they have been noticed during defecation. These attacks of blueness were at about one month intervals. Two months later had an attack of blueness and the doctor found it was due to marked difficulty in respiration. Came to the Out-Patient Department one month later and was breathing hard at this time. X-ray was taken at this time and diagnosis of tracheal stenosis from thymic pressure was made and she was referred to the x-ray department for therapy. She was given four treatments, the last one five days previous to entrance. The week previously the child was so well, treatment was omitted. Since the last treatment the breathing has become worse. For two days previous to admission the child seemed much worse. Has had a cold the past few days.

**Physical Examination.** Well developed and nourished child, exceedingly sick, looks pale

and lips are blue. Extremities cold, pulse very weak. Temperature 96. Respiration labored and noisy, most marked stridor being on expiration. Head, normal size and shape; anterior fontanelle closed and depressed. Ears negative. Nose, pinched expression; alae nasi dilating with each inspiration; slight serous discharge. Eyes, pupils slightly dilated and react to light. Mouth, normal; throat clean. Neck, no stiffness; glands slightly enlarged. Chest, well arched, symmetrical, equal expansion. Lungs, no dullness, no abdominal breath sounds, no râles. Heart, normal size, no murmurs. Abdomen, level, soft, tympanitic, no tenderness, small mass lower right quadrant, hard, about the size of a walnut and movable. Liver edge 1-1.5 cm. below costal border. Spleen not felt. Kidneys were not felt. Genitalia negative. Extremities normal. Reflexes normal. Ophthalmoscopic examination normal. Carbon dioxide tension (Marriott and Howland method) 10-15. Catheter specimen of urine: Milky, cloudy, acid, 1003; sugar, 0; acetone, 0; albumin, positive; microscopic examination, broken down pus cells. Child was given stimulation but did not respond, and died.

**Autopsy.** Four hours post mortem. Body is that of a poorly nourished, poorly developed child. Length 75 cm. Skin is smooth, elastic and pale, except for slight lividity of the back. Parietal eminences are prominent. Anterior fontanelle is closed and depressed. Pupils are equal and measure 4 mm. No discharge from nose or ears. No palpable nodes in neck. Epiphyses are enlarged at the anterior end of the ribs, and the lower ends of the bones of the forearm and the lower legs. There is slight anterior bowing of the lower legs 4 cm. above the ankles. Rigor mortis is present.

Abdominal cavity: Subcutaneous fat is pale yellow, 4 mm. thick. Omentum is scanty and contains a small amount of yellow fat. Intestines are pale, and distended with gas and contain numerous firm fecal masses, particularly the cecum. Appendix is small, 6 cm. in length, with a long mesentery. Peritoneum is smooth and glistening. There is no free fluid. Diaphragm is at the fifth interspace on the left, and at the fifth rib on the right. Pleural cavities: No free fluid. Pleura is smooth and glistening. There are no adhesions. Pericardial cavity: No free fluid. Pericardium is smooth and glistening.

Heart: Weight, 50 grams; tricuspid valve, 2.4 cm.; pulmonary valve, 1.8; mitral valve, 2.1; aortic valve, 1.5; left ventricle 0.3; right ventricle, 0.1. Heart muscle is firm and deep red in color. Endothelium is smooth and glistening. Cruor clot fills all chambers. Heart valves are all translucent and smooth. Coronary arteries are patent. Subpericardial fat is scanty. Pericardium is smooth and glistening.

Lungs: Surface is smooth and shiny,

dark red, mottled with brown. Cut surface is pink and exudes a frothy fluid on pressure. Lungs are crepitant throughout. Bronchi contain a little mucus, but their lining is smooth and pale, and they contain no foreign bodies.

Organs of the neck: Tongue is moist and red, with many firm nodules 2 to 4 mm. in diameter on its upper surface near the base. Tonsils are firm, pale, 5 mm. across. Epiglottis is 9 mm. long and covers a tracheal opening 4 mm. across. Trachea is empty and its lining smooth, white and glistening. Thymus extends down in front of the tracheal bifurcation for 3 cm. on each side, in thickness it is 2 to 3 mm.

Spleen: Weight, 27 grams. Surface is deep purple, glistening, and slightly wrinkled. There are five notches along the outer border 3 to 5 mm. deep. Cut surface is dark red with a delicate tracery of fine white lines and tiny gray dots between them.

Gastrointestinal tract: Oesophagus is of uniform diameter throughout, its lining is smooth and white. Stomach is of moderate size, free from adhesions; its outer surface is smooth and pink, its inner pale and plicated. Intestine is thin-walled, pink, and in its lower portion the Peyer's patches are present. Lining of cecum is red, that of the colon, pale. Mesenteric lymph-nodes are numerous, firm, and average 7 mm. in diameter.

Liver: Weight 250 grams. Surface is smooth, shining, and dark purple. Consistency is firm. Cut surface is chocolate-brown with the lobules standing out as brown spots. Gall-bladder is small and thin-walled. Bile-ducts are patent.

Pancreas is firm and of good size. Cut surface is yellowish, with white lobulations.

Adrenals are 2.5 cm. in length. Cut surface shows the normal markings distinctly.

Kidneys: Each measure 6.5 cm. from pole to pole, average 2.5 cm. in width and 2.5 cm. in thickness. Foetal lobulations have persisted. Capsule is adherent, leaving an uneven, reddish surface. On section, the cortex is 5 mm. thick in places, elsewhere markings are lacking, the kidney tissue being a uniform pink. The calyces are very large, some of them extending to within 6 mm. of the outer surface of the kidney; their lining is 1 mm. thick, white and opaque. The pelvis of each kidney contains 15 to 20 cc. of cloudy, white urine, and its wall is 1 mm. thick, tough but not reddened. Both ureters are greatly dilated, being 2 cm. in diameter over a large part of their course, and entering the bladder as thick-walled ducts 5 mm. in diameter.

Pelvic Organs: Bladder is smooth and white on its outer surface, its wall is 3 mm. thick, and inelastic; and its inner surface is wrinkled, white, with innumerable red dots. It contains 40 cc. of cloudy, white urine. Urethra

is patent. Uterus is 2 cm. long, 1 cm. wide, and 3 mm. thick, firm and pale. Ovaries and oviducts appear to be normal.

Anatomical Diagnosis: Congenital cystic kidneys; congenital dilatation of ureters; chronic inflammation of bladder; emaciation.

#### REFERENCES.

- <sup>1</sup> Garrod, Batten, and Thursfield: *Diseases of Children*, p. 618.  
<sup>2</sup> Dunn: *Pediatrics*, p. 458.

### Book Review.

*The Autonomic Functions of the Personality.*

By EDWARD J. KEMPF, M.D. New York and Washington: Nervous and Mental Disease Publishing Co. 1918.

This interesting volume is an analysis of behavior stated in psychoanalytic terms and also in terms of the autonomic nervous system. It really is devoted to a study of the influence of the autonomic nervous system upon the structure and behavior of the individual. The old distinction of mind and body in the make-up of personality is gradually being eliminated, on the one hand by Adler, who approached the problem of the neurotic character from the organic rather than the functional side, and on the other by this recent contribution of Kempf on the psychology of the emotions and the part they play in the personality of the individual.

It seems from Kempf's material, that the old James-Lange theory of peripheral origin of the emotions, which had been gradually relegated to the scrap-heap of outgrown ideas, has been here revived and made more basic in the light of the newer studies of the vegetative nervous system. According to the writer, affective cravings or emotions have a peripheral origin in certain motor-sensory functions of the autonomic apparatus. The autonomic functions of the organism tend to utilize and organize the proficient functions so as to acquire a maximum of gratification for the environment with a minimum expenditure of energy. The author sees in the autonomic nervous system the primitive means for recording the organic cravings of the individual and in the cerebrospinal system, the means for adopting the organism to its environment so as to secure a satisfaction of its cravings.

The familiar psychoanalytic concepts of conflict, repression and the unconscious, thus receive a new interpretation in anatomical and physiological terms. It is a useful book for those interested in the problems of normal and abnormal behavior, particularly from the standpoint of determinism. Dr. Kempf has done his work well and in a masterly fashion.

## THE BOSTON Medical and Surgical Journal

Established in 1812

An independently owned Journal of Medicine and Surgery, published weekly under the direction of the Editors and an Advisory Committee, by the BOSTON MEDICAL AND SURGICAL JOURNAL SOCIETY, INC.

THURSDAY, JUNE 10, 1920

## EDITORS

ROBERT M. GREEN, M.D., *Editor-in-Chief and Manager*GEORGE G. SMITH, M.D., *Assistant Editor*WALTER L. BURRAGE, M.D., *For The Massachusetts Medical Society*

## ADVISORY BOARD

EDWARD C. STREETER, M.D., Boston, Chairman

WALTER P. BOWSER, M.D., Clinton

WALTER B. CANNON, M.D., Cambridge

HARVEY CUSHING, M.D., Brookline

HOMER GAGE, M.D., Worcester

REID HUNT, M.D., Boston

LYMAN A. JONES, M.D., Swampscott

ROGER I. LEE, M.D., Cambridge

ROBERT B. OSGOOD, M.D., Boston

MILTON J. ROSENBAUM, M.D., Brookline

ALFRED WORCESTER, M.D., Waltham

SUBSCRIPTION TERMS: \$5.00 per year, in advance, postage paid for the United States, \$6.56 per year for all foreign countries belonging to the Postal Union.

An editor will be in the editorial office daily, except Sunday, from twelve to one p.m.

Papers for publication, and all other communications for the Editorial Department, should be addressed to the Editor, 126 Massachusetts Ave., Boston 17. Notices and other material for the editorial pages must be received not later than noon on the Saturday preceding the date of publication. Orders for reprints must be returned in writing to the printer with the galley proof of papers. The Journal will furnish free to the author, upon his written request, one hundred eight-page reprints without covers, or the equivalent in pages in the case of articles of greater length. The Journal does not hold itself responsible for any opinions or sentiments advanced by any contributor in any article published in its columns.

All letters containing business communications, or referring to the publication, subscription or advertising department of the Journal should be addressed to

BOSTON MEDICAL AND SURGICAL JOURNAL

126 Massachusetts Ave., Cor. Boylston St., Boston 17, Massachusetts

## IMPROVEMENT IN HOSPITAL SERVICE.

EVERY state medical association in the United States has its part in the present universal movement for the betterment of hospital service. Every association now has its own committee which is studying the hospital situation in its state in coöperation with the Council on Medical Education of the American Medical Association. The Council has obtained, through reports, correspondence, and other methods, data relative to all large hospitals in the country and each state committee has been supplied with the data relating to the institutions in its state. Through closer familiarity with the hospitals, or by inspections, the state committee can verify these data and make a reliable report to the state association and to the Council. The committee in Massachusetts is: Dr. R. L. DeNormandie, Boston; Dr. E. L. Davis, Springfield; and Dr. Homer Gage, Worcester.

For convenience and in order to secure uniformity of reports from the forty-eight com-

mittees regarding the relative efficiency of hospitals, blanks furnished by the Council call for a rating of all hospitals in classes A, B and C, grouped also according to the special class of patients cared for. This rating is not for publication but will aid the Council in the preparation of a list of hospitals which are considered worthy of approval. These lists are subject to frequent revision so that the names of other hospitals can be included as soon as sufficient improvements are made to warrant their being approved. State committees are urged to report promptly to the Council any instances where such improvements have been made.

The purpose of the work is to aid the hospitals in providing for their patients the best possible service. It is in no way to injure those which are honestly endeavoring to provide such service. To help along, every possible assistance will be given to individual hospitals by the Council or by the local state committee in establishing such changes as will make them worthy of approval.

Forty-two state committees have reported progress in connection with the latest survey and thirty-four have turned in reports regarding hospitals inspected and graded, which have more than half the entire bed capacity of all general hospitals in the country. Meanwhile, this work of the Council is not conflicting with, or duplicating the splendid work being done by the American College of Surgeons, the Catholic Hospital Association, the American Hospital Association, or other agencies. In fact the work of each agency is evidently complementing that of the others.

At the recent meeting in New Orleans, the House of Delegates of the American Medical Association registered an intense interest in the improvement of hospital service and authorized the trustees to provide generously for that work. This work has been so intimately related to that of the Council on Medical Education that the name of this Council was changed to the "Council on Medical Education and Hospitals."

Further enlargement of hospital work by the American Medical Association is assured and in this work each state is destined to have an important part. Toward this end each association is urged to make its hospital committee permanent and to retain on it not only those

who will be active but also those who can do the work in the most efficient and unbiased manner. Hospitals, at present, form the closest link between the medical profession and the public, and the medical profession should do all it can to aid the hospitals to provide the very best service possible.

#### THE TREATMENT OF TUBERCULOSIS IN GENERAL HOSPITALS.

At the present time, with thousands of cases of tuberculosis among discharged soldiers entitled to medical aid and treatment at the hands of the Public Health Service, we find ourselves confronted by the fact that practically nowhere will general hospitals admit this class of patients; moreover, there is almost everywhere throughout the United States a lamentable shortage of hospital facilities for those ill with tuberculosis. The opening of general hospitals to this class of patients would do very much more than provide relief for a large class of unfortunates; it would undoubtedly contribute enormously to the efforts now being made to control tuberculosis.

As conditions are now, the interne serving his time in any of the general hospitals has practically no opportunity whatever to familiarize himself with the diagnosis and treatment of pulmonary tuberculosis. It is small wonder, therefore, that so large a proportion of the general practitioners fall so far short in their diagnoses of pulmonary tuberculosis. The present practice also fosters the erroneous belief in some miraculous virtue in climate in the treatment of tuberculosis, yet those familiar with the disease recognize that it is the proper use of fresh air which constitutes the valuable element in treatment at the various well-known sanatoria.

In an effort to make better provision for the tuberculous among discharged soldiers, and at the same time to help bring about an improvement in our campaign against tuberculosis, Dr. Hugh S. Cumming, Surgeon General of the U. S. Public Health Service, sent the following telegram to the American Medical Association, while it was in session in New Orleans, La.:

"I desire to urge more active participation by the general practitioner and by general hospitals in the treatment of tuberculosis. To insure earlier diagnoses, properly train internes and other personnel, popularize treatment in

the home climate, provide additional facilities. I earnestly endorse the resolution passed by the National Tuberculosis Association in 1916, recommending that general hospitals should admit tuberculous patients and provide separate wards for that purpose. Sanatoriums and specialists in tuberculosis will always be needed and we should have more of them, and I believe that success in the anti-tuberculosis campaign is largely dependent upon first, convenient facilities for observation and prompt treatment of patients with open tuberculosis; and second, in a sharpened perception and higher degree of skill by which the family doctor will make early diagnosis or even forestall the development of clinical tuberculosis in the adult before a definite diagnosis is possible. To provide adequate care for tuberculous ex-service men and others, to protect infants from infection, enlist the aid of the general practitioner, allay phthisiophobia, and improve home treatment of tuberculosis, the opening of general hospitals to this most common of all serious diseases will materially assist."

#### PROPOSED LAW TO PREVENT ILLEGAL ABORTION.

In most large communities there are one or more men who have a right to practice medicine but have so far forgotten their obligations to the profession and the state as to become the murderers of countless unborn children. These men continue to ply their nefarious business although the state has made it a felony punishable by fines and imprisonment. In other words, the punishment does not act as a deterrent. Occasionally a man is punished, but most of them go free although their business is public knowledge in the community. Such conditions are a disgrace to the community and to our country. With little modification of the present laws the practice could be made so dangerous that it would practically cease.

To accomplish this we would recommend that the state recognize that there are conditions which demand the sacrifice of a child for the benefit of the mother; except in extreme emergency, however, no physician should be allowed to perform such an operation without a confirmation of his diagnosis by another physician and after the history of the case has been reduced to writing and signed by both physicians. In those very rare cases where consulta-



tion cannot be had the physician performing the operation should be required to file with the district attorney a full statement of the case, which should be accompanied by a history signed by the physician and by the persons furnishing the information. Such a law would protect the reputable physician while it would make it difficult for the illegal abortionist to continue his work.

J. W. BREWER.

#### MEDICAL NOTES.

**THE AMERICAN PEDIATRIC SOCIETY.**—The thirty-second annual meeting of the American Pediatric Society was held on May 31, June 1 and 2 at the Moraine Hotel, Highland Park, Illinois. Regular sessions were held in the morning, afternoon, and evening of the first day, with a Council meeting at 9 o'clock in the evening. On June 1 a case report session was held in the morning, a regular session in the afternoon, and in the evening there was a dinner followed by a discussion of graduate work in pediatrics. On June 2 a business meeting was held for the members of the society at 9 o'clock, followed by a child hygiene session in the morning and a regular session in the afternoon.

**UNIVERSITY OF MARYLAND.**—The Maryland State College of Agriculture and the University of Maryland School of Medicine has been combined under the name of the University of Maryland by a bill recently passed by the Maryland legislature. The legislature has appropriated the sum of \$42,500 for each year for the next two years for the medical school. \$186,476 for the use of the other departments of the university in 1921, and \$165,416 for 1922. An appropriation of \$203,000 was made for buildings and equipment.

**REPORT OF VENEREAL DISEASES.**—During the month of March, 1920, 23,573 cases of venereal diseases were reported to the State Boards of Health by physicians, clinicians, hospital superintendents, and others, and there were 9,260 new admissions to the clinics operating under the joint control of the United States Public Health Service and the State boards of health. There were administered during the month

26,395 doses of arsphenamine. Six states have not submitted reports.

**MEDICAL AND SURGICAL HISTORY OF THE WAR.**—It has been announced that the Surgeon-General of the United States Army has asked for a grant for the publication of the medical and surgical history of the war. A large part of the material for this history has been collected and its publication depends upon the action of Congress. The first portion of an unofficial history of the Canadian Army Medical Corps was completed at the end of 1918, and it is expected that the German history in nine volumes, will be ready this year. Considerable progress has been made already with the British official medical history of the war.

**MEMORIAL MEDAL TO FLORENCE NIGHTINGALE.**—As a memorial to Florence Nightingale and to give international recognition to the work of trained nurses in all parts of the world, a medal was established in 1912 at an International Conference of Red Cross Societies held in Washington. The first awards of this medal were postponed because of the outbreak of the war in 1914; but it has been announced that fifty of these medals will be awarded in 1920. The medal, which is of silver and enamel, bears a portrait of Florence Nightingale and the inscription, "Ad memoriam Florence Nightingale 1820-1910." On the reverse side is the inscription, *Pro vera misericordia et cara humanitate perennis decor universalis*, surrounding a space reserved for the name of the recipient. On a white and red ribbon which is attached to the medal is displayed a laurel wreath in green enamel surrounding a red cross on a white ground.

#### BOSTON AND MASSACHUSETTS.

**RECOVERY OF HINSDALE PHYSICIAN.**—Dr. Willis L. Tucker of Hinsdale, recently struck by a train, has left the House of Mercy Hospital greatly improved and will make a complete recovery.

**MEASLES AND WHOOPING COUGH IN BOSTON AND VICINITY.**—Since the beginning of the year, measles and whooping cough have caused the death of 132 children of school age in Boston and its vicinity, and thousands of other chil-

dren have been kept from their studies by these diseases. The records of the health department show that the cases of both diseases have been more numerous this year than in the corresponding months of the last ten years. Since January 1 there have been 1383 cases of whooping cough and 85 deaths, and 4798 cases of measles and 47 deaths. This outbreak has been attributed by Dr. Woodward to the fact that there have been relatively few cases of both diseases during the last few years, during which there have accumulated a large number of children who have never had either whooping cough or measles and consequently are not immune to them. He has issued a warning to parents advising them to have children examined at once by a physician if they have a slight cold, watery eyes, a slight cough, or what appears to be a cold in the head.

There has been an average of more than 200 cases of measles reported each week since January 1. One week only 199 cases were reported and in another week only 193 developed; but many of the weeks showed more than 250 additional cases each and at one time 326 cases were reported in a single week. In January there were 12 deaths from measles; in February, 11 deaths; in March, 9; in April, 8. Last year in the corresponding period there was relatively little measles, the records showing only 196 cases and only two deaths. In 1918, in the corresponding period, there were fewer cases than this year, the number being 4,030, but the deaths were more numerous, the number then being 75.

The number of whooping cough cases since January 1 were 1383. In the same period last year there were 250 cases and in the previous year 1047. The deaths this year have totalled 85 as compared with 11 in the same period last year and 56 in the preceding year.

**DORCHESTER PHYSICIANS' WIVES ASSOCIATION.**—The annual meeting of the Dorchester Physicians' Wives Association was held recently, and the following ladies were elected for the ensuing year: President, Mrs. Samuel Crowell; Vice-President, Mrs. William Johnston; Treasurer, Mrs. H. F. R. Watts; Recording Secretary, Mrs. M. H. A. Evans; Corresponding Secretary, Mrs. W. C. Emery; Auditor, Mrs. F. S. Parsons; Press Correspondent, Mrs. C. E. Allard. Directors for 1920-21: Mesdames J. W. Lane, A. E. Sherburne, E. P. Day, J.

Treanor, W. H. Parker, F. G. Phillimore, G. M. Mason, R. W. Brayton, A. W. Stearns, H. MacLeod.

**SPRINGFIELD ACADEMY OF MEDICINE.**—The May meeting of the Springfield Academy of Medicine was held in Springfield on the evening of May 11, 1920. Dr. Arthur H. Crosbie of Boston delivered an address on "Prostatic Obstruction." The next meeting will not be held until September.

**RECRUITING OF PHYSICIANS FOR MEDICAL CORPS.**—An effort is being made by the Boston district recruiting staff to secure physicians for the Medical Corps, for service in army hospitals and similar institutions. It is hoped that nine thousand medical men may be secured from New England for this service before November 1, 1920. Physicians desiring to remain in the vicinity of their homes while serving in the Medical Corps can be enlisted for the Coast Artillery forts in Boston and other New England harbors, and those who possess the required educational qualifications will be sent to Fort Banks, where they will be instructed in laboratory technique. A school for x-ray manipulation is maintained in Washington, and those who so desire may be instructed in this branch of the service. Application for information about service in the Medical Corps should be made to Major Leonard W. Hasset of the Medical Corps, at 3 Tremont Row.

**MASSACHUSETTS DENTAL SOCIETY.**—At the fifty-sixth annual meeting of the Massachusetts Dental Society the following officers were elected for the coming year: President, Dr. Frank P. Simpson of Pittsfield; vice-presidents, Dr. Frank P. Barnard of Worcester and Dr. William Rice of Boston; secretary, Dr. Edward J. McQuillian of New Bedford; treasurer, Dr. Joseph T. Paul of Boston; editor, Dr. Charles E. Parkhurst of Boston.

**ESSEX NORTH MEDICAL SOCIETY.**—The annual meeting of the Essex North Medical Society was held at Lawrence on May 5, 1920, and Dr. Alfred Worcester of Waltham and Dr. Howard A. Streeter delivered addresses before the Society. The following officers were elected: President, Dr. D. D. Murphy of Amesbury; vice-president, Dr. F. W. Snow of Newburyport; secretary, Dr. J. F. Burnham

of Lawrence; and auditor, Dr. F. N. Coffin of Haverhill.

**NOMINATION OF DR. WILLIAM J. BRICKLEY AS MEDICAL EXAMINER.**—Dr. William J. Brickley of Boston has been nominated associate medical examiner for Suffolk County, to succeed Dr. Oscar Richardson, who has resigned. Dr. Brickley was born in Boston in 1874. He was graduated from Harvard Medical School in 1907 and began practising in that year. He is surgeon in charge of the Haymarket Square Relief Station. Dr. Brickley has been a lieutenant commander in the Navy, and was in active service during the war.

**GIFT OF FIVE MILLION DOLLARS TO HARVARD MEDICAL SCHOOL.**—The estate of Mr. Joseph R. Delamar of New York, under whose will Harvard, Columbia, and Johns Hopkins Universities are the chief beneficiaries, has been found to be valued at \$32,282,927, instead of \$20,000,000, the estimate made at the time of his death in 1918. The three medical schools will receive, therefore, the sum of \$5,541,401 each.

**VISIT OF EUROPEAN PHYSICIANS TO BOSTON.**—Five eminent European physicians are making a tour of this country in order to study the methods of medical instruction. They have recently left Boston, where they visited the Harvard Medical School and the leading hospitals in the city, for Philadelphia and Baltimore.

While in America the physicians are the guests of the National Board of Medical Examiners of the United States. They are accompanied through this section of the country by Dr. David A. Strickler of Denver and Dr. Horace D. Arnold of Boston, both members of the national board. They have attended a meeting of the American Medical Association at New Orleans and have visited the leading medical centers of the middle West.

The physicians and the medical organizations they represent are: Sir Humphrey D. Rolleston, Royal College of Physicians of London; Col. H. J. Waring, Royal College of Surgeons of London; Dr. Norman Walker, Royal College of Physicians and Royal College of Surgeons of Edinburgh and the Royal Faculty of Medicine and Surgery of Glasgow; Profs. Gustave Roussy and E. E. Desmarest of the University of Paris.

**ADDITION TO ST. JOHN'S HOSPITAL.**—Exercises for the opening of the addition to St. John's Hospital, Lowell, were held on May 11. The institution was established in 1867 by the Sisters of Charity. The new building is of practically the same size as the old St. John's Hospital building, with which it is connected by tunnels at every floor. It is four stories high, finished in red brick, with reinforced concrete and steel entering into various parts of its construction. There are wide corridors, spacious piazzas, and sun porches on every floor, and the roof will be used for the benefit of convalescent patients. In the basement will be located the out-patient department, which will give special attention to women patients. On the first floor there are double private rooms for male patients and also ward beds; the second floor is to be devoted to the children's general ward; on the third floor are private rooms and wards for women. The operating rooms, laboratories, and x-ray room are on the fourth floor.

**HEALTH WEEK AT SIMMONS COLLEGE.**—During the first week in May, a health week was celebrated at Simmons College. The exhibit was arranged for two purposes: first, to tell those who are healthy how to keep their health and to tell those who are not healthy how to become so. The first part of the exhibit, presenting the health facts brought out by the war, took the form of a tented army clinic in charge of Prof. Curtis M. Hilliard, professor of biology and public health at the college. The second part of the exhibit attempted to portray what each community can now do in child welfare, industrial health, tuberculosis, and social diseases; a display was made of material lent by the American Museum of Safety, the National Child Welfare Organization, the Child Health Organization of New York, the Massachusetts State Department of Health, and the Metropolitan Life Insurance Company. One day was devoted to children, who were instructed in the means of bodily welfare. Babies were weighed, and the proper clothing and the method of bathing babies was demonstrated. Professor Hilliard gave a lecture on "The Nation's Teeth," and Professor Howard E. Hamlin, professor of physiology at Simmons, took as the subject of his address, "Stand Straight, Sit Straight, Go Straight." Another speaker was Dr. Valeria H. Parker of Hartford, who is

a social hygiene worker for the National League of Women Voters and assistant educational director of the American Society of Hygiene Associations.

**BERKSHIRE DISTRICT MEDICAL SOCIETY.**—On April 29, 1920, the Berkshire District Medical Society held its annual meeting and elected the following officers: President, Dr. Ayers P. Merrill; vice-president, Dr. George P. Hunt; secretary, Dr. O. L. Bartlett; treasurer, Dr. Charles T. Leslie. At this meeting Dr. Walter E. Fernald, of Waverley, gave a very interesting talk on Feeble-mindedness.

#### NEW ENGLAND NOTES.

**HOG CHOLERA IN VERMONT.**—An outbreak of hog cholera has occurred at four farms near Montpelier, Vermont. Dr. A. J. Defossett, deputy commissioner of livestock, has placed these farms under quarantine for forty days, and arrangements have been made for a supply of serum to be furnished at cost to those who apply for it. The farmers have been asked to report immediately any death from the disease. The animals which have been exposed have been vaccinated and none will be allowed to be shipped from the places under quarantine until that is removed.

**NEW HAMPSHIRE SURGICAL CLUB.**—Surgeons of New Hampshire and Massachusetts attended the semi-annual meeting of the New Hampshire Surgical Club held at St. Joseph's Hospital, Nashua, New Hampshire, on May 4. The morning session was devoted to clinical demonstrations and several unusual and difficult operations were performed. In the afternoon, lectures on surgical subjects were given by Dr. Frank E. Kittredge of Nashua, Dr. J. M. Gile of Hanover, and Dr. J. F. Thompson of Portland, Maine. Dr. Herbert L. Smith, president of the society, presided at the meeting.

**WAR RELIEF FUNDS.**—The New England branches of the French Orphanage Fund and the Italian Fund have announced the following contributions:

|                             |              |
|-----------------------------|--------------|
| French Orphanage Fund ..... | \$594,696.54 |
| Italian Fund .....          | 327,902.15   |

#### AMERICAN CLIMATOLOGICAL AND CLINICAL ASSOCIATION.

The following preliminary program has been announced for the thirty-seventh annual meeting of the American Climatological and Clinical Association to be held at the Bellevue-Stratford Hotel, Philadelphia, on June 17, 18, and 19, 1920:

President's Address, Lawrason Brown, M.D., Saranac Lake, N. Y.

1. Diagnosis of Myxedema, By James B. Anders, M.D., Philadelphia.

2. Tubercle of the Lung Moderately Advanced: Artificial Pneumothorax—Apparent Cure—Military Service in France—Gun-Shot Wound Penetrating Pneumothorax—Chronic Empyema—Lantern Slides. By J. B. Elliott, Toronto, Canada.

3. Some Aspects of Relationship between Certain Cases of Bronchial Asthma and Pollen-Sensitization. By Walter J. Baetjer, Baltimore, Md.

4. Studies in Vibrations Causing Pulmonary Physical Signs. By Charles M. Montgomery.

5. Study of Cases with Regard to Gastric Sugar Tolerance on Basal Metabolism. By Nelson J. Russell, Buffalo, N. Y.

6. Adrenalin Hypersensitiveness in Suspected and Definite Tuberculosis. By F. H. Heise and L. Brown, Saranac Lake, N. Y.

7. Treatment of Tuberculosis of the Larynx. By Alexius M. Foster, Colorado Springs, Col.

8. Diatetics for the Tuberculous. By J. Madison Taylor, Philadelphia, Pa.

9. Lymphocytosis as a Diagnostic Sign of Focal Infection. By Judson Daland, Philadelphia, Pa.

10. Ultimate Prognosis in Vascular Hypertension. By George M. Piersol, Philadelphia, Pa.

11. A Simple Alphabetical Medical Key-work System for Indexing (Lantern slides). By William J. Mercur, Philadelphia, Pa.

12. Postural Rest for Pulmonary Tuberculosis. By Gerald B. Webb, Colorado Springs, Col.

13. Study of Recovered Tuberculosis Patients by Stereo-roentgenograms. By Bertram H. Waters, Loomis, N. Y.

14. Occupation of the Active and Arrested Case of Pulmonary Tuberculosis. By Bayard T. Crane, Rutland, Mass.

15. Study of Tuberculosis Patients Who Had Influenza during the Epidemic of 1918. By John B. Hawes, 2d, Boston, Mass.

16. W. F. A. Phillips, Charleston, S. C. Subject to be announced later.

17. Empyema, Communicating with Abscess of the Left Breast. (Lantern slides.) By John J. Lloyd, Rochester, N. Y.

18. A Study of the Progressive Changes in the Aorta and Lung as Shown by X-Ray in Tuberculosis and Syphilis. By Cleveland Floyd, Boston, Mass.

19. Odds and Ends in Tuberculosis. By Charles O. Probst, Cleveland, Ohio.

#### RECENT DEATH.

**DR. HENRY JAMES MILLARD**, a retired Fellow of the Massachusetts Medical Society, died at his home in North Adams, May 30, 1920, aged 84 years. He was a graduate of the Berkshire Medical Institution of Pittsfield in 1864, and had practised in North Adams all his life.